Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 -CERTIFICATE OF DEATH and 2 executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY Balto. City o. COUNTY Carroll Maryland the attending physician and campletely filled in by the tunkit nermit. Then please remove carban papers. Pages 1 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) CLENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Balto, City 30 11 Mos. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NO T YES Springfield State Hospital Lauretta Ave NAME OF Middle 4. DATE Manth Dov Year Last DECEASED (Type or print) Sidney OF Edgar Armiger DEATH March AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours WIDOWED DIVORCED 1-18-15 Male White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)

Painter COUNTRY? INDUSTRY law requires that the death certificate Maryland II.S.A 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Sydney Edgar Armiger Grace Rice IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Lauretta Ave. (Yes, no, or unknown) (If yes give wor or dates of service) Springfield St. Hosp. Records Marka Cana None cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-transit burial, cremati ONSET AND DEATH PART I. DEATH WAS CAUSED BY Mycardial infarction. IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove Pulmonary tuberculosis. vears rise to immediate couse (a), DUE TO stating the underlying couse be retained by the haspital ar attending as the has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use Health Schizophrenic reaction, chronic undifferentiated type. NO this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. (Stote) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) Hour o.m. foctory, street, office bldg., etc.) Not While of work ot work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased from 4-25-66 , to 3-5-67 ____, 19____, that (1) (we) last 3 shauld I with the S and that death occurred at 1:15aM, from causes and an the date stated above. sow the deceased olive on 3-5-67 19 . 220. SIGNATURE 22b. DATE SIGNED **ATTENDING** 5 DIRECTOR PHYS. directar, poge should be filed 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D. Sykesville, Maryland 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) Bur Tal (Specify) Loudon Park Cem. Baltimore. Md. 3-7-67 25b. REGISTRAR'S SIGNATURE **ADDRESS** 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave. 1967

MARYLAND STATE DEPARTMENT OF HEALTH



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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

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TO HOSPITAL 32 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

cian.	by the attending physician and completely.	rmit. Then please remove carbon papers. Payes I and 2 should	r removal, and in any event within 72 hours after death.	
death. Page	2 > IO FUNERAL. GTOR: After this certificate has been signed by the attending physician and completely in by the funeral	director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pap	E be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.	

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 02196

03800				U5414
1. PLACE OF DEATH	1	2. USUAL RESIDENCE	(Where deceased lived, If institu	tion: Residence before edmission)
CARROLL	MARYLAND	MARVIK	AND b. COUNTY	PRICLL
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate limits, write RUR.	AL end give nearest town)
WESTMINSTER	76	NESTI	MINSTER	06-1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp	itel, give street eddress)	d. STREET ADDRESS		e. IS RESIDENCE
185 WILLIS ST.		185 WIL		YES NO Z
3. NAME OF First	Middle	Lest 4	DATE Month	Day Yeer
(Type or print) WESLEY CH	AYBAUGH B	ROOKS	DEATH MARC	# 10 1967
5. SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED B.	DATE OF BIRTH	9. AGE (In yeers IF UN last birthday) Mon	HOER 1 YEAR IF UNDER 24 HRS.
MALE WHITE WIDOWED		100.19 1890	76 yrs.	
done during most of working life, even if retired	ND OF BUSINESS OR INDUSTRY		& State, or foreign country) 1:	2. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME	174 & DEPOSIT	14. MOTHER'S MAIDEN N	MINSTER, MD	U.S.Q.
JOSEPH D. BROOK	15	MINNIE	- GOSNELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16.55 (Yes, no, or unkown) (Hyes give were refetes of service)		NFORMANT	Address	
N6 - 21	5-10-1506 DR.	C.L. BILLINGS	LEA WESTMIN	STER MD.
18. CAUSE OF DEATH [Enter only one cause per li	ne for (a), (b), and (c).]		,	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	nice Con	~ a		3-5-47
4221 DUE TO				
Conditions, if eny, which) (b) Cana	lia-renal	- Vousaul	andiseus.	e 1 years
gave rise to immediate cause		V. C. 191. C. 18		
cause last. (c) Engle	lysemanel	rovine be	meliti	5 years
Z PART II. OTHER SIGNIFICANT CONDITIONS CON	TRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMINA	L DISEASE CONDITION GIVEN IN	PART 1(e) 19. WAS AUTOPSY PERFORMED?
Cinterio-	achrosi	1		YES NO Z
	TRIBE HOW INJURY OCCURED.		rt I or Pert II of item 18.)	
U (IF EITHER, NOTIFY MEDICAL EXAMINER)				
		CE OF INJURY (Home, ferm, pry, street, office bldg., etc.)	20f. (City or town)	(County) (State)
Hour s.m. While ef work	1401 111110	ory, street, office blog., etc.)		
21. I certify that (I) (this hospital) attend	led the deceased from.	1-10 19	66 10 3-10	, 194.7, that (I) (we) last
saw the deceased alive on3 - 10				
22e. SIGNATURE		ATTENDING ME	D. STAFF	22b. DATE SIGNED
VLB 11 lines	elea M.	- Z		3-10-67
22c. PHYSICIÁN'S NAME (Type)	/	22d. ADDRESS	. 4	~ 0 1
C. Le. 130/11/19		Wests	mus ur,	morycond
236. BURIAL, CREMATION, 236. DATE THEREOF REMOVAL (Specify)	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City, town or	county) (Stete)
BURIAL 3/13/67	MESTMINSTE	CEMETERY	WESTMINS	TER MD.
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	/ AAAD	BY REGISTRAR 256. REGISTRA	AR'S SIGNATURE
4.5. Impsite has	minsty, 1	MAK.	1 4 196/	

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03421 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) physician and campletely filled in by the funeral en please remave carbolt papers. Pages 1 and o. COUNTY o. STATE b. COUNTY Baltimore City MARYLAND Maryland Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ve carbon papers. Pagevent, within 72 hours Baltimore lyrs.7mos.19dys e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 2313 N. Charles St. Springfield State Hospital YES | NO X 3. NAME OF First Middle 4. DATE Doy Year DECEASED RUTH BROWN (Type or print) DAN FORTH DEATH MARCH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH NEVER MARRIED 82 birthdoy) Months Dovs Hours X 9-28-1884 White WIDOWED DIVORCED Female 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY andi Dept. Store Work Maryland II.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME the attending phys Dan Forth Unk. IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 215-03-0258-D Records, Springfield State Hospital crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH Mesenteric thrombosis Davs IMMEDIATE CAUSE (o) signed by **DUE TO** Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse as the Page 4 may be retained by the hospital ar attending O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome with cerebral arteriosclerosis, with psychotic NO reaction far 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work pe 19____, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. and that death occurred at 3-3-67 M. from causes and an the date stated above saw the deceased alive an. 22b. DATE SIGNED 22a SIGNATURE **ATTENDING** 3-3-67 DIRECTOR PHYS. Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Antonius Glahn, M. D. NAME (Type) Sykesville, Maryland directar, shauld 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) eedam Kesville TIAL 25b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR FUNERAL DIRECTOR Municipales VR A15 (4) 1967 20 M 1/66

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(VI)		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
funeral and 2 death.		03422 CERTIFICATE OF DEATH 03416	
event, within 72 hours after death.	1.	PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before a state b. COUNTY	admission)
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	7	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. GITY OR TOWN (if outside corporate limits, write RURAL and give nearest rown) nanchester 12 days 1401 1401	ist town)
		9 NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RE	SIDENCE FARM?
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İ	3.	DECEASED OF 2	ear
1	5.	SEX 6. COLOR OR RACE 7 MARDIED NEVER MARDIED 18. DATE OF BIRTH 19. ACF (In years LIFTINDER LYFARIETINDI	
	10	1ALE White WIDOWED DIVORCED 4/14/92 14 yrs. Months Days Hours	
	dyr	8. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR III. BIRTHPLACE (County & State, or foreign country) 12. GITIZEN OF WHAT COUNTRY?	л
	13.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
		EZRA BYERS MARY YINGLING	1133
ı	15. (Ye	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address es, no., or unkown) (If yes give war or dates of service)	- 4 0
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	ETWEEN
1			DEATH
		433.0 DUE TO (1 1 0 11 1 80.00	100
		Conditions, If any, which gave rise to Immediate Course to Immediate OUE TO DUE	1
	-	underlying cause last. (c)	N. S.
	CERTIFICATION	PERFOI	
1	TIFIC	YES 20a. AGCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.)	NO X
		OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County)	(State)
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		21. I certify that (I) (this hospital) attended the deceased from the deceased from the deceased alive on the date stated as the deceased alive on the date at the deceased alive on the date at the date at the deceased alive on the date at the date at the date and the date at th	
		22a. SIGNATURE 22b. DATE SIGNED	
		22c. PHYSICIAN'S DIRECTOR PHYS. 3-1/-6/	
		NAME (Type) WICHENN SPEICHER MD Westwarter mid	
	23a.	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (S	state)
	24.	FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	4-
		2. 5. myers, Jr. Westminte md MAR 1 4 1967 Jelianles Judges	
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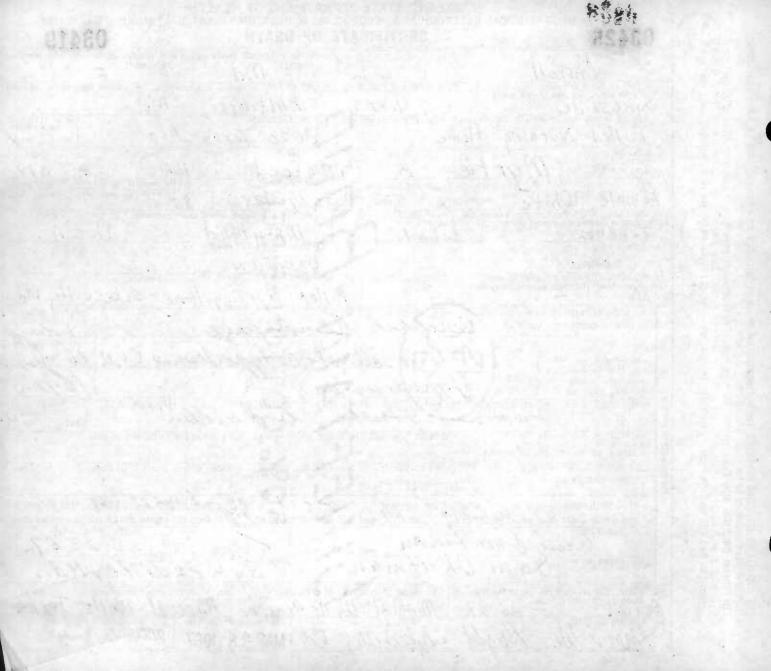
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03424 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death pup completely filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b.,COUNTY o. STATE Carroli MARYLAND Maryland Carroll b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b. write RURAL and give nearest town) Tife Rural-Sykesville Rural-Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 10 R.D. 2 R.D. YES NO T NAME OF Middle First Last 4. DATE Month Day Year DECEASED Carroll E. Cook March 1967 DEATH (Type or print) S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED remove last birthday) Davs Hours Oct.3.1890 Male Colored WIDOWED DIVORCED the attending physicion ond sit permit. Then please rem 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Carroll Co., Md. Laborer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME James Cook Phoebe Myers 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates of service) 5 Mrs. Daisy M. Cook 17-16-5228 Same As 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-tronsit p ONSET_AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUF TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO F the hospital or for 20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.) of detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) Nat While at work at work , 1967 that (I) (we) last 21. I certify that (1) (this hospital) attended the deceased fram. , 196 H., to ro Hospital or Attent Poge 4 may be retoined and that deoth occurred of M. from causes and an the date stated above saw the deceased olive on 22b. DATE SIGNED 22a SIGNATURE ATTENDING STAFF DIRECTOR M.D. PHYS PHYS. 22d.) ADDRESS 22c. PHYSICIAN'S NAME (Type) director, 23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OF COMMANDRY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Fairview Methodist Carroll 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Charles 1967 Waltz Box 241 Sykesville,

MARKET PARK SEX

	(-)		DIVISION O	F STATISTIC	AL RESE	ARCH AND	RECORDS	. 301 W. PRE	STON STRFF	H T, BALTIMORI	F 1 MARYL	ΔΝΠ
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after death the funeral ges 1 and 2 after death		1.	PLACE OF DEATH a. COUNTY	- 11				2. USUAL RES a. STATE	IDENCE (Where det	eased lived, If institu		before admission)
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hours	in by Pag nours		Sukesville	give nearest town	1)	7 4	ARS	BAI	timner	Mcl.	KOKAL and Blac	y = -
bod 1	filled ipapers. in 72 h		d. NAME OF HOSPITA		V (if not in h	ospital, give st	reet address)	d. STREET ADD	RESS	^	0.	IS RESIDENCE ON A FARM?
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withi	completely filled in by the ve carbon papers. Pages 1 event, within 72 hours after	3.	NAME DF DECEASED (Type or print)	Mul	st + 10	Midd	0	AM FOR	4. DATE DF DEATH	Month	Day 23	Year 19 67
uted	com ove c	5.	SEX 6. C	COLOR OR RACE	7. MARRIED	☐ NEVER MA	RRIED 8	. DATE OF BIRT	415	AGE (In years IF	UNDER 1 YEAR	
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þe	physician a sin please re val, and in	dur	ing most of working li Teacher	fe, even If retired) 11	NDUSTRY Chool	55 UK	M AL	CI HAN	or foreign country)	12. CITIZEN O	A
icate	val val	13.	FATHER'S NAME			211001			MAIDEN NAME		() · () ·	7 /
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requires that the death certificate be executed within 24	s been signed by the attending is the burial-transit permit. Then rior to burial, cremation, or remove	(Ye	. WAS DECEASED EVER is, no, or unkown) (If ye	es give war or dates of	service) 16.	SOCIAL SECURI	17 NO. 17.	INFORMANT	Ursing 1	Home - Sy	kesvili	le. Md -
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hat t	ed b tran-tran 1, cre		4/4/3 X	WAS CAUSED BY: MEDIATE CAUSE (reco	ua	liner	ewage.		3	days
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PHYSICIAN: The law requires that the heart or attending physician	tificate has been for use as the b		cause (a), stating underlying cause las	the DUE 1	(c) H	yperf	emi	Per	//		10	yes
The law	certificate has hed for use as t. of Health prior	CERTIFICATION	PART II. OTHER SIGNI		NS CONTRIBO	TING TO DEATH	BUTNOTRELAT	TED TO THE TERMI	NAL DISEASE CONT	OITION GIVEN IN PA		WAS AUTOPSY PERFORMED?
N. S.	for 1	TIFIC	20a. ACCIDENT WAS	UNDERLYING [7]	20h [DESCRIBE HOW	INJURY OCCUP	RED. (Enter natu	are of Injury In Pa	rt I or Part II of It	YES	□ NO □
PHYSICIAN	ched ched pt. o		OR CONTRIBUTING [] CAUSE OF DEAT MEDICAL EXAMIN	H ER)							
PHY	After this certiful be detached for State Dept. of	MEDICAL	20c. TIME OF INJUR Hour a.m.		While	NJURY OCCURR		E OF INJURY (Hor y, street, office bl		City or town)	(County)	(State)
DING		M	p.m. 21. I certify tha	at (I) (this hospi	at work		ed from	Day 13	, 1965 to	Harch 23	1967 tha	t (I) (we) last
TTEN	TOR: Shou th th		saw the decease	7.4	work!	196	and .	death occurred	1/2	om the causes an		
OR A	DIREC Se 3 ed wi		22a. SIGNATURE	mi Dr	rut	may	M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF 2	2b. DATE SIGN	67
D HOSPITAL OR ATTENDING	or FUNERAL DIRECTOR: A director, page 3 should should be filed with the		22c. PHYSICIAN'S NAME (Type)	San	101	Kufn	1an	22d. ADDRES		es vill	e, K	d.
O HO	direc shoul	23a	BURIAL, CREMATION REMOVAL (Soccify)	N, 23b. DATE TI	HEREOF	23c. NAME	OF CEMETERY	OR CREMATORY	23d. LO	CATION (City, town	or county)	(State)
F	=	24	UTIAL	15-26	-67	ADDRES	Al WY	1/5 (4)48	REC'D BY REGIS	TRAR 25b. REGI	CE//S STRAR'S SIGNA	TURE
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY a. STATE Carroll Maryland Montgomerv MARY! AND Department after death. funeral may be b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 5yrs.5mos.5dvs Gaithersburg Sykesyille | Dyrs om OS ogys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) the 5 e. IS RESIDENCE d. STREET ADDRESS ON A FARM? ay Is 3 to 1 State hours Springfield State Hospital Cedar Ave. Ext. No oc YES 2, and PM3. NAME OF DATE Month Year First Middle DECEASED OF the GRIGGAR B. 1 PHILLIP 1967 DEATH MARCH (Type or print) within 6. COLOR OR RACE | 7. MARRIED death. If a e Pages 1, with form I AGE (In years | IF UNDER 1 YEAR) IF UNDER 24 HRS 5. SEX DATE OF BIRTH NEVER MARRIED last birthday) Months Days Hours Male White 2-12-1892 WIDOWED 7 DIVORCED TO 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) Give COUNTRY? during most of working life, even if retired) Janitor - Gaithersburg High School Virginia pages 1 In any 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Phillip Cregger Mary Fulter 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unkown) | (If yes give war or dates of service) permit. removal. 229-03-9009 Records. Springfield State Hospital No INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction cremation, or r Minutes. Severe coronary arteriosclerosis with insufficiency Conditions, if any, which gave rise to immediate DUE TO (a), stating the ed as a burial, underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY PERFORMED? CBS associated with alcohol intoxication, without qualifying phrase YES X NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) 20a. EXTERNAL CAUSE WAS No injury - patient found slumped by bed; pronounced dead at 5:35 PM. PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 3 should bagent, price 20e. PLACE OF INJURY (Home, farm, 2Df. (Clty or town) (County) (State) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Hour a.m. While Not While at work at work p.m. 21. I certify that I took charge of the remains described above, held an Autopsy Inspection inquiry and in my ppinion Undetermined manner Suicide Homicide death resulted from: Natural causes x Accident he CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER director. Glenn Speicher. NAME (Type) M. D. 23b. DATE THEREOF 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, REMOVAL (Specify) Montg. Rockville, Parklawn 3/6/67 Buria. 254 REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Rockville VR A15ME Tyson Wheeler Funeral Home Rockville, DATE 35DD 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Reside PLACE OF DEATH o. COUNTY o. STATE Maryland Carroll Montgomery MARYLAND 24 haurs after c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) haurs Chevy Chase Lmos.3dvs. Svkesville attending physician and completely filled in sermit. Then please remave carbon papers. carbon papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 4817 Chevy Chase Blvd. Springfield State Hospital NO T YES | PHYSICIAN: The law requires that the death certificate be executed within 3. NAME OF Middle 4. DATE Lost Month Doy Year DECEASED 13 MARCH 67 CLARA LOUISE DECKER 19 (Type or print) DEATH IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH last birthdoy) Months Dovs Hours Female White 6-5-1874 X DIVORCED or remayal, and in any WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Housewife INDUSTRY COUNTRY? Ohio II.S.A 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Charles Plaisted Sarah Mc Lean 16. SOCIAL SECURITY NO. 17. INFORMANT Address 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 579-60-4294 Records, Springfield State Hospital burial-transit pern burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia Days signed by **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. Conditions, if ony, which gove Arteriosclerotic cardiovascular disease Years rise to immediate couse (a), DUE TO stoting the underlying couse far use as the k Health priar ta b TO FUNERAL DIRECTOR: After this certificate has been Minimal pulmonary tuberculosis, active Months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CBS assoc. with senile brain disease, with psychotic reaction WAS AUTOPSY PERFORMED? NO X YES [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) Hour o.m. Not While foctory, street, office bldg., etc.) 19 ot work ot work shauld be 21. 1 certify that (I) (this haspital) attended the deceased fram 11-10-66 ____, that (I) (we) last M. fram causes and an the date stated above. saw the deceased alive on 3-13-67 19 and that death accurred at 22b. DATE SIGNED 22a. SIGNATURE 3-14-67 DIRECTOR director, page shauld be filed 22d. ADDRESS Springfield. State Hospital 12c. PHYSICIAN'S Julian Radzykewycz, M. D NAME (Type) Sykesville, Maryland 23d. LOCATION (City or Town) (County) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, REMOVAL (Specify) 3-16-1967 Cedar Hill Cemetery Buriel Joseph Gawler Wash DC Inc. Wisc. Ave, 5130

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	4 EX4		03428 CERTIFICATE OF DEATH	03422
	after death the funeral ges 1 and after death		1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution:	Residence before admission)
	the the after	-	CARROLL MARYLAND A. STATE MARYLAND B. COUNTY OF TOWN (if outside corporate limits to LENGTH OF SYMPHOLIC AND CA	RROLL
			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL WESTMINSTER) WESTMINSTER	L and give nearest town)
-			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE
	ithin 24 hustely filled soon papers within 72 h	00	141 W. MAIN ST. 141 W. MAIN ST.	ON A FARM?
	- W		8. NAME OF First Middle Last 4. DATE Month OF OTTO OF OF THE STATE OF THE MONTH OF THE	Day Year
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	and		EMALE WAILE WIDOWED DIVORCED MARKET /2/889 77 vrs.	R 1 YEAR IF UNDER 24 HRS. Days Hours Min.
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	icate be physicia n please val, and		HOUSE-WIFE — CARROLL CO. MD 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	U.s.a.
	death certificate te attending phys permit. Then ple ion, or removal, a		WILLIAM K. LEPPO AMELIA C. FRIDING	=p
	eath certifi attending ermit. Ther n, or remov		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Address Yes, no, or unknown) (If yes give war or dates of service)	
	e death the att t permi		- 219-34-490X MRS LILLIE MAY PETRY LIT	TLESTOWN PA
		6	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
	2.2 a + "	84	PART I. DEATH WAS CAUSED BY: Carcusant Liverbith as eites	192
	ires tl physi n sign burial		Conditions, If any, which I the surface to mellitus	gears
	w requirements been as the bustion to business.	87	gave rise to immediate cause (a), stating the DUE TO	years
	255	1	underlying cause last. (c) THE CONTRIBUTIONS CONTRIBUTIONS TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)) 119. WAS AUTOPSY
	N: The Late or at ifficate For use Health	2		PERFORMED?
	Agrapo	September	20a. ACCIDENT WAS UNDERLYING DOBATH OR CONTRIBUTING DOBATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	this deta	NEO IO A	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.)	ounty) (State)
	NG by be be Stat	ME		
	the R. in St.		21. I certify that (I) (this hospital) attended the deceased from a first 1963, to March 4 196 saw the deceased alige on March 3 1967, and that death occurred at 2.65 M, from the causes and on	7, that (I) (we) last
	E E E		22a. SIGNATURE 22b.	DATE SIGNED
	TAL OR may be AL DIRE (AL DIRE), page de filed v		22c. PHYSICIAN'S ATTENDING MED. STAFF PHYS. 3	-4-67
	F = \$ e	1	22c. PHYSICIAN'S NAME (Type) 22d. ADDITESS	
	Fage 4 r Page 4 r C FUNER director,	2	33. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or company)	ounty) (State)
	E E S	-	BURIAL 3/7/69 KRIDERS CEMETERY KURAL, WESTMIN	STER, MD
	VR A15 (4)	1	1 - 20 - 10 Color of the total of the color	15 SIGNATURE
	20M 1/65	5	property withman, me DATE MAR ? 1961 for	and Judge

2396 CARROLL MARYLAND CARROLL 31 MESTIMINISTER WESTERNASTER 141 W MAIN ST 141 16 199111 37 ELSIE MENES DUTTENERS MARCH 4 6 FEMALE HALTE & MORUH /2 1889 TT - CARROLL CO. MD U.S. C. HOUSE WIFE WILLIAM K. LEAPO AMFLIA C. FRIDINGER "ZIG - 34-4407 MRS LULIE MAY PETRY, LITTLETTOWN PA BURGHL 3/9/69 NOWERS CEMETERLY ROOM, NEWSTRINGTER, 160 Fragray fristmeter met

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE Maryland b. COUNTY Carrol1 Carrol1 any delay is "ecessary, 2, and 3 to the funeral PM3. Page 5 may be MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Department after dea Life Rural, Westminster Rural. Westminster d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS State 00 Westminster, Md. R. D. 1 Westminster, Md. R. D. 1 NO X YES NAME OF First Middle Last DATE DECEASED 書 3/15/67 (Type or print) DEATH 19 4 s after death. If a 18. Give Pages 1, along with form 5. SEX AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 6. COLOR OR RACE last birthday) Months Davs Hours Male White NX 8/27/1889 WIDDWED DIVORCED l and a 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) INDUSTRY COUNTRY? Item 18. c. along Retired Farmer Farm pages 1 in any Carroll County, Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Jerome Dutterer Ellen Hull File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address R. D. 1 (Yes, no, or unkown) (If yes give war or dates of service) permit. removal, cate should be executed within the word "pending" in pencil i the Chief Medical Examiner's No 219-20-2357 Mrs. L. Oliver Dutterer, Westminster, Md. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (a) DUF TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the O underlying cause last. (c) ed as burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? use to b ND V YES R: This certifica cate, writing the forwarded to t be DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING T PIE CAUSE OF DEATH. 3 should agent, 1 MEDICAL TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 2De. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) at work Not While factory, street, office bldg., etc.) Hour a.m. EXAMINER: the cerrit 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion Undetermined manner Natural causes X. Accident Suicide Homicide death resulted from: DIRECTO CHIEF MEDICAL EXAMINER Þ your Page ASSISTANT MEDICAL EXAMINER SIGNATUR for 0 DEPUTY MEDICAL EXAMINER **EXAMINER'S** director. retained street, pro-cown or county NAME (Type) BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. REMOVAL (Specify) St. Marys Cemetery 0 3/18/67 Silver Run, Carroll Co. Md. Burial REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NERAL DIRECTO 25a. VR A15ME Littlestown, Pa. 3500 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER:

rs after deoth. If any delay is 18. Give Pages 1, 2, and 3 to

This certificate should be executed within 24 hours after deoth.

FOR STATE		03430	MEDICAL EXAMINER'S	CERTIFICATE C	OF DEATH	03424
EALTH DEPT!		PLACE OF DEATH D. COUNTY		O STATE	Where deceased lived, if institution: Residue.	,
to to sge lift.		Carroll	MARYLAND	Man	cyland C	arroll
delay ond 3 M3. Pog tment er deat		CITY OR TOWN (If autside carparate limits		c. CITY OR TOWN (If a	utside corparate limits, write RURAL and	give nearest tawn)
2, ond 3 to PM3. Page portment of after death.		write RURAL and give nearest town) Finksburg	-rural 4 months	Finl	ksburg (rural)	06-1
-		I. NAME OF HOSPITAL OR INSTITUTION (If no		d. STREET ADDRESS		e. IS RESIDENCE
Source De			, <u></u> ,	מת		ON A FARM? YES NO 🖾
th. ges and a foot		RD2		RD2		
24 hours after deoth. If any delay is in they 18. Give Pages 1, 2, and 3 to a confide along with form PM3. Pages 1 and 2 with the State Deportment of ny event within 72 hours after death.		NAME OF Fir DECEASED	rst Middle	Lost	4. DATE Month	Doy Year
in d g v g v		Type or print) Jam		Edmondson	DEATH 3	2 19 67
on tie	S.	6. COLOR OR RACE	The state of the s	8. DATE OF BIRTH	a lost hintheless thank	ER 1 YEAR IF UNDER 24 HRS.
18 e o e o tr		male white	WIDOWED DIVORCED L	'eb. 16,19	42 25 yrs.	. Joseph Hilling
ond	10a	USUAL OCCUPATION (Give kind of work done	10b. KIND OF BUSINESS OR	11. 8IRTHPLACE (Stote	or foreign country) 12.	CITIZEN OF WHAT
1 lon y eve		ng most of working life, even if retired) Tree Trimmer	INDUSTRY	Carroll	Co., Md.	COUNTRY?
thin 24 mine(1) in 1 pages 1 in any		FATHER'S NAME		14. MOTHER'S MAIDEN		
		Unknown	1	Helen	V. Edmondson	
d with perfect fixor File and	15			INFORMANT	Sameddr Ass #	<u> </u>
red ol iii.	(Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? s, no, ar unknown) (If yes give war ar dates a	of service) 240 26 1022 Mr		et A. Edmondsor	1
e executed pending" i ef Medicol isit permit. removol,				S. Margar	ec M. Hamonasor	
ex end end Me		18. CAUSE OF DEATH (Enter only one cou	use per line for (o), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH
should be e he ward "per to the Chief I buriol-tronsit mation, or re		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE	(0) Carbon monoxide po	oisoning as	sociated with smok	e onstrand brain
P-tro		9160 DUE	10- and soot inhalat:	ion		
we the the original strice		Conditions, if any, which gave	(b)			
the to to but		rise to immediate cause (a), stoting the underlying cause				
ficate ing the ded to ded to os o		lost.	(c)			
This certificate should be executer ficate, writing the ward "pending" I be farwarded to the Chief Medicol Id be used as a burial-transit permit. Or to burial, cremation, or removal,			ONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CO.	NOTION GIVEN IN PART 1(a)	19. WAS AUTOPSY
writ farwar used buria	NO	TAKT II. OTHER SIGNIFICANT CONDITIONS CO	ONIKIOOTINO TO DEATH DOT NOT KEENED TO	THE TERMINANE DISEASE CO	nominal office in time (i.e.)	PERFORMED?
his arte, to to	CERTIFICATION	20- EVIEDNAL CALLEE WAS	TOOL OFFICE HOW IN HIS VICE INDEED	/F-t t :- t :- t	Death - Death - City - 103	YES NO
d b	RTIF	20a. EXTERNAL CAUSE WAS PRIMARY ☑ CONTRIBUTING ☐	20b. DESCRIBE HOW INJURY OCCURRED.		Part I or Part II at Item 18.)	
NER: II certifice hould be iles. should I	II CE	CAUSE OF DEATH.	conflagration			
sh sh ent ent ent	MEDICAL	20c. TIME OF INJURY Manth, Day, Year Haur a.m.	Maria New Milette of force	CE OF INJURY (Home, form	n, 20f. (City or town)	(County) (State)
AN e tle tle tle tle tle tle tle tle tle t	ME	12:51 xx 3 2 19	67 of work at work tr	tary, street, affice bldg., etc. ailer park	Finksburg-rural	,Carroll,Md.
UTY MEDTCAL EXAMINER: This only, please execute the certificate, reral director. Page 4 should be fabre retained for your files. RAL DIRECTOR: Poge 3 should be used its designated agent, prior to learn its designated ogent, prior to learn its designated of the control of the		21. I certify that I tank charge	e af the remains described abave, he	eld an Autapsy 🕱	Inspection , Inquiry	, and in my apinian
sercal use exe ector. P ined fo RECTOR lesignot				ide , Hamicide		
se se schonen		death resolved from.	Action E	CHIEF MEDICAL		_
MEDIA please I directo retained L DIREC		ACTUAL /10 mm m	4 9 10-1-	ACCIETANT ME	DICAL EXAMINER X	22. DATE SIGNED
AR AR		SIGNATURE ACCOUNT	· · · · · · ·	M.D. ASSISTANT MEDIC		10/67
TO DEPUTY MEDICAL EXAM necessory, please execute the the funeral director. Page 4 5 moy be retained for your TO FUNERAL DIRECTOR: Page Health or its designoted age		EXAMINER'S Werner U	J. Spitz, M.D.		t, city, tawn, ar county)	3/2/67
Ed Fee	230	. 8URIAL, CREMATION, 23b. DATE THE	EREOF 23c. NAME OF CEMETERY OR	CREMATORY	23d. LOCATION (City or Town)	(County) (State)
0 = 20 E		REMOVAL (Specify) Burial 3/4/19				, Md.
0	24	FUNERAL DIRECTOR	ADDRESS	250. REC'	D 8Y REGISTRAR 2Sb. REGISTRAR	S SIGNATURE A
VR A15ME (5)	C.		41 Sykesville, Md		MAR 6 1967 gcl	carles judge
6M 1/66	1		, , , , , , , , , , , , , , , , , , , ,	DATE	MAIN O MAIN	C Er

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tee time deat	1.	PLACE DF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Res a. STATE b. COUNTY Carroll MARYLAND	idence before admission)
hours after death ad in by the funera ars. Pages 1 and 2 hours after death	n	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Reval po
n 24 y filled paper thin 72			YES NO
d within 24 I	3.	NAME OF DECEASED (Type or print) Alice Gertrude Eyler DEATH MArch	Day Year 1967
executed within and completely and completely remove garbon any event, with	5.		YEAR IF UNDER 24 HRS Days Hours Min.
physician and inval, and in	1/0a duri	. USUAL DCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CIT	IZEN OF WHAT
tificate ng phys hen pl moval,	13.	FATHER'S NAME Christian Wike Summa H. AUTS	
eath cel attendi ermit. I	15. (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT through the service 2/6-22-7622	- w.l
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within retained by the hospital or attending physician. CTOR: After this certificate has been signed by the attending physician and completely should be detached for use as the burial-transit permit. Then please remove garbon is should be state Dept. of Health prior to burial, cremation, or removal, and it any event, with		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULL TO Conditions, if any, which gave rise to immediate cause (a), stating the DUE TO DUE TO DUE TO	INTERVAL BETWEEN ONSET AND DEATH
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hospital certifi ched fo pt. of H		20a. ACCIDENT WAS UNDERLYING COURSED. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER)	
JING PHYSICI of by the host After this ce d be detached State Dept.	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work at work 19 at wo	ity) (State)
ATTENDIN retained to CTOR: Aff should by with the Si	-		, that (II) (we) last e date stated above.
OR / be		22a. SIGNATURE 11 7 ourd M.D. ATTENDING MED. STAFF 22b. DAY M.D. PHYS. DIRECTOR PHYS. 3/	30167
PITA 4 ma ERAL or, p		22c. PHYSICIAN'S NAME (Type) W. H FOATA M.D. MANCHESTER	et d
TO HOS Page TO FUN direct should	23a	Bremoval (Specify) 4/1/67 Leisters Cemetery Rural Westman.	signature ml.
VR A15 (4) 15M 4-64		J. 2. myers J., Westminster, md. DAAPR 3 1967 goliarles	Judge

Erman H Adrs 24-22-7622 Berial 41167 Looke Comting hard white Toll

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03426	
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DMAR 2 3 1967

e. IS RESIDENCE ON A FARM? YES NO S

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES X

and in my apinion

22. DATE SIGNED 3/20/67

(Stote)

NO

(State)

Md.

IF UNDER 24 HRS.

FOR STATE	03433 MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	3426
HEALTH DEPT.	1. PLACE OF DEATH 0. COUNTY Carroll MADVIAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Resident o. STATE b. COUNTY	
2, and 3 to PM3. Page	b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest tawn) MARYLAND C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside corporate limits, write RURAL and give	rroll e neorest town)
aath. If any ages 1, 2, ith farm PN state Depar	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress)	Rural - Sykesville d. STREET ADDRESS Mill	e. IS RESIDEN ON A FARM
farr farr	Liberty Dam	Rt. 10akland Road	YES NO
e / 8 - e	3. NAME OF First Middle DECEASED (Type or print) GLORIA A. I	Lost 4. DATE Month OF FAGGELLI DEATH March	Doy Year 19 19
after of sive alang with		B. DATE OF BIRTH 9. AGE (In years IF UNDER lost birthdoy) Months	Doys Hours
ortho		lug • 22, 1933 33 yrs.	
within 24 haurs pencil in Item 18: xaminer's Office in Item 18: ile pages land and and and and and and and and and	100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIIE INDUSTRY		TIZEN OF WHAT UNTRY?
hin ncil ninel page	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
d within in pencil Examine File pag	Joseph Fusco	Maria Neubauer	
- i - i - i - i - i - i - i - i - i - i	(Yes, no, or unknown) (If yes give wor or dotes of service)	INFORMANT Address	
xecuted nding" ir Medical permit.		· Tony Faggelli Same As #	
"per "per nief I	1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE (AUSE (o) Asphyxia		INTERVAL BETWE ONSET AND DEAT
ward ward the Ch rial-tra	7/3 X DUE TO		
shauld ne ward a the Ch burial-tra	Conditions, if ony, which gove (b) Drowning.		
s certificate shaul b, writing the war farwarded ta the used as a burial- iaval, and in any	stoting the underlying couse lost.		Marin Train
certifi arward arward used a aval, ar	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0)	19. WAS AUTOPS PERFORMED
:: This cert tificate, wri Id be farwa uld be used ar remayal,	200. EXTERNAL CAUSE WAS PRIMARY XI OF CONTRIBUTING TO Threw self in:		YES X NO
certificate, auld be faces.	20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Port 1 or Port II of item 18.)	
ner: T certific hauld b iles. shauld an, ar n			
5 3 章 S 6	Ol Davis and Control of the control	tory street office bldg etc.)	unty) (Sta
EXAM ute th uge 4 yaur Page	XXX 3/19 17 07 of work 🖂 of work	Dam Car	roll M
_ a d b d _`	21. I certify that I taak charge of the remains described abave, he		and in my ap
MEDICAL please exec director. P etained for DIRECTOR. ta burial,	death resulted fram: Natural causes , Acident , Suic	:ide ☒, Hamicide ☐, Undetermined manner ☐ CHIEF MEDICAL EXAMINER ☐	
UTY MEDITY, please eral direct be retaine be retaine priar ta bu	SIGNATURE () Carle & Celly	M.D. ASSISTANT MEDICAL EXAMINER [3]	22. DATE SIG
EPUTY SSary, F funeral ay be r INERAL	EXAMINER'S	DEPUTY MEDICAL EXAMINER	3/20/6
ecessary, place funeral commay be re FUNERAL I ealth priar	NAME (Type) Charles S. Patty	Address (Street, city, town, or county)	0,20,0
necessary, the funeral 5 may be 70 FUNERAL Health pric	230. BURIAL (REMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR		(County) (Stot
P	Burial 3/22/1967 Lakeview Me	morial Gardens Carroll C	. bM . 0
VR A15ME (5)	C. M. Waltz Box 241 Sykesville, Md	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SI	

BSASO TELESTORON ELORGICA DE LEVILLA CONTRA DE L

7-1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE I, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03428
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
) HEALIN DEI II	a. COUNTY a. STATE b. COUNTY SERVICE
the gard	b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
essa fune nay rrtme dea	PURAL WESTMINSTER 144RS QURAL WESTMINSTER MONTH
the 5 r	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
any delay is necessary, 2, and 3 to the funeral PM3. Page 5 may be the State Department 72 hours after death.	RT #5 SALEM BOTTOM ROAD RT#5 SALEM BOTTOM RP YES NOW
dela md 3 1. P	3. NAME OF First Middle Last 4. DATE Month Day Year OF MARCH TANDERS OF THE OF
any of 2, ar PM3.	(Type or print) KLAKN FUGENE GREVNAN DEATH /TA/CH LND 190/
ath. If all ages 1, 2 form P 2 with	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 14 EAR IF UNDER 15 EAR
de sage	WIOOWED DIVORCED HOS STATES OF WISH OF WORK done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
er deal	during most of working life, even if retired) INDUSTRY
ours aftern 18. Girang pages 1 in any	13. FATHER'S NAME
ours m 18 e al e al pag	RUSSELL WILLIAM FREVMAN RUTH LOUISE LITTLE
24 ho Trice office and	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address ATE 5 (Yes, po, or unknown) (Illyes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS ATE 5
r's rill ir.	YES 1962-1961 LIS SE TOLL TATHER RUSSELL WITKEYMAN MESTAWARK
AL EXAMINER: This certificate should be executed within 24 hours after death. If any delicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Ir files. CTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the St designated agent, prior to burial, cremation, or removal, and in any event within 72 hours.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
Exal Exal or	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skell & Neck of Swilden
"pending" in 'f Medical Exar t burial-transit I cremation, or i	Conditions to any which I
be e pen Medi urial ema	Conditions, If any, which gave rise to immediate put to DUE TO
a b	underlying cause last.
she would as the	TO THE PERSON OF
ficate shower the worr of the Chiange as used as to burial,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. PERFORMED? YES NO Y 2Da. EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING CAUSE OF DEATH.
R: This certificate, writing forwarded to 3 should be agent, prior	2Da. EXTERNAL CAUSE WAS PRIMARY OF OF DEATH. 2Da. EXTERNAL CAUSE WAS PRIMARY OF OF DEATH. 2Da. EXTERNAL CAUSE WAS CAUSE OF DEATH. 2Da. EXTERNAL CAUSE WAS PRIMARY OF OF DEATH. 2Da. EXTERNAL CAUSE WAS CAUSE OF DEATH.
nis c writ rarde nould	CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20c. PLACE OF INJURY Home, Farm, Local County (State)
forw forw	2 Hour a.m. 3 While Not While Statory, street, office bidg., etc.)
AL EXAMINEI the certificates the should be refiles. CCTOR: Page designated	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, and In my opinion
L EXAN he cer should files. FOR: P	death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner
CTO des	CHIEF MEDICAL EXAMINER
MEDICAL EX. ecute the c Page 4 shou for your files L DIRECTOR: or its design	SIGNATURE SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER TO 3-2-67
Y ME execution Page 1 for AL D	OEPUTY MEDICAL EXAMINER X
O DEPUTY MEDICAL please execute the director. Page 4 si retained for your fi O FUNERAL DIRECTO of Health or its de	NAME (Type) NAME (Type) No. CALL NAME (Type) NAME
directand of Fe	REMOVAL (Specify) 3/6 /67 DEER PARK OEM, SMALL WOOD MD-
- M	24. FUNERAL DIRECTOR ADDRESS MO 25a, REC'D BY REGISTRAR 25b. REDITRAR SIGNATURE
VR A15ME	Theres & Saffell h MEST MINSTER DATE MAR 3 1967 June
35DD 4-64	

FREEDOM DESCRIPTION OF THE PROPERTY OF THE PRO THE STREET OF TH

	16		DIVISION OF STATISTICAL	RESEARCH AND RECORDS, 301 W. PRESTON STR	EFT. BALTIMORE 1 MARYLAND
÷	F 2 4		03435	CERTIFICATE OF DEATH	03429
after death	funeral and 2 death.	1.	PLACE OF DEATH a. CDUNTY	2. USUAL RESIDENCE (Wher	e deceased lived, If institution: Residence before admission)
ftor		_	b. CITY DR TOWN (if outside corporate lin	MARYLANO MITTALY L	CORPORATE CONTROLL CORPORATE Ilmits, write RURAL and give nearest town)
2	A Bass	V	write RURAL and give nearest town) ESTMINSTER	MINITES UNIAN	BRIDGE MIT RURAL
24 hours	ed ir ers. 72 ho		d. NAME OF HOSPITAL OR INSTITUTION (IF	not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE DN A FARM?
		2	ARROLL CO. GENER	PAL HOSPITAL BORHER JOHN	ROAD YES NO
executed within	pletely arbon it, with	3.	NAME OF First DECEASED (Type or print) SAM IIAL	77011	ATE Month Oay Year EATH MARCH 16 1967
100	e ve	5.	057	MARRIED NEVER MARRIEO 8. OATE OF BIRTH	9. AGE (In years IF UNOER 1 YEAR IF UNDER 24 HRS.
Joyo	a a a	100		100WED 01VORCED 00T21-1903	63 yrs.
		dur	USUAL OCCUPATION (Cive kind of work done ng most of working life, even if retired)	INDUSTRY M MADDY A A A	State, or foreign country) 12. CITIZEN DF WHAT COUNTRY?
a ter	physi physi ple al, a	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAM	IE USH
i t	ding pl Then remova		EDWARD FURA	PY AMY SAPI	PINGTON
4	ttend mit. or r		WAS DECEASED EVER IN U.S. ARMEO FDRCES s, no, or unkown) (If yes give war or dates of servi	16. SDCIAL SECURITY NO. 17. INFORMANT	Address MD
20	he a peri		18. CAUSE OF DEATH [Enter only one cau	213-01-6006 NHKGHKLI FUK	RY UNION BRIDGE
me remires that the death certificate the	an. d by the arransit perr cremation,	П	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute myo cardial infactor	about 2 120 urs
+	or attending physicial cate has been signed use as the burial-translath prior to burial, or		4201 OUE TD	211	,
100	g phy en si bur bur		Conditions, If any, which gave rise to Immediate (b)_	atheroscherolic heart dises	gens years
0	nding bee		cause (a), stating the underlying cause last.		
100	atter atter e has se as th pri	NOIL	/ (0)_	ONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE	CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
1,4	ficate for use for use Health	FICA	AND AND INCOME.		YES ND X
NAIG	44 17 1	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURREO. (Enter nature of injury	n Part I or Part II of Item 18.)
BUVEIGIA	thi thi	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m.	factory street office bldg etc.)	Of. (City or town) (County) (State)
	by be be	MED	p.m. 19	at work at work	1 1
ATTENDIN	the the		21. I certify that (I) (this hospital) saw the deceased alive on 3	050	to 3 16 67, 19 , that (I) (we) last I, from the causes and on the date stated above.
	i iii co >		22a. SICNATURE	and that death becomed at 1 42 m	22b. PATE SICNED
00			Jos. H. Cari	M.O. ATTENOING MEO. PHYS. MEO. DIRECTO	OR PHYS. 3 14 67
n unebital	age 4 ma FUNERAL rector, p		22c. PHYS CIAN'S NAME (Type) JH CA	RICOFE UNION BRI	DOE MD
000	Page 4 O FUNER director should t	23a	BURIAL, CREMATION, 23b. DATE THER	EOF 23c. NAME DF CEMETERY OR CREMATORY 23d.	CLDCATION (City, town or county) (State)
	0	24	FUNERAL DIRECTOR	AODRESS) 25a. REC'D BY R	//1//022
	VR A15 (4)		DA Hartzler & Sono	Umon Bridge Med OATMAR 2 (1967 Icharles Judge
	20M 1/65	-	-0-	→	

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03436 CERTIFICATE OF DEATH death. requires that the deoth certificate be executed within 24 haurs after death by the funeral Pages 1 and puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission a. COUNTY b. CITY OR TOWN (If autside corparate limits. c. LENGTH OF STAY IN 16 write RURAL and give negrest tawn) WKS E.STMINSTE d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? hin carbon 3. NAME OF First Middle event, wit 4 DATE Month Day Last Year. DECEASED MARGIE MARRICH (Type or print) DEATH S SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED physician and com en pleose remove last birthday) Months Hours DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind of work dane 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) **NDUSTRY** COUNTRY 2 CARRUL 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, ar unknown) (If yes give war ar dotes of service) GONI, TER, WESTMINSTER 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) burial-tronsit PART I. DEATH WAS CAUSED BY: MYOCARDIAL INFARCTION IMMEDIATE CAUSE (o) ò DUE TO signed Conditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO far 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City ar town) (Caunty) (State) 20c. TIME OF INJURY Manth, Day, Year Haur o.m. factory, street, affice bldg., etc.) Nat While at work Page 4 may be retained by 21. I certify that (1) (this haspital) attended the deceased from 3-10-1967, ta 3-24-1967, that (1) (we) last 3-24-19 67, and that death accurred at 3 20 M, fram causes and an the date stated above saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED X M.D. DIRECTOR ADDRESS 4 BOX 41B 22c. PHYSICIAN'S HANS NIPKOW in D WESTUNSTER MIP NAME (Type) director, g 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (Stote) (County) REMOVAL (Specify) 24 FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR 25h REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

arlen. The state of the s WALL THE TALL I I DEPOSITE THE THE STANDARD WITH BETTER THE SELL PART HE WEST WOOD STANDARD AND THE Control of the second of the properties of the Control of the second of The state of the s for executation of 12, 219 1 48 and an execution and State of the state

MARYLAND STATE DEPARTMENT OF HEALTH Item 2. Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 over CERTIFICATE OF DEATH 03437 requires that the death certificate be executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission PLACE OF DEATH a. COUNTY o. STATE b. COUNTY Carroll MARYLAND Montg. Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville, and campletely filled in by the remove carban papers. Pages C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ban papers. Pag within 72 hours o Olney Vrs. I mo. e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Home. ON A FARM? Brook Grove Foundation Nursing Springfield State Hospital NO TE YES 4. DATE Month NAME OF First Middle Doy Year DECEASED Edith GIBBON M. March 1967 DEATH B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Months Doys Hours 12-27-1883 female WIDOWED white DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) attending physician opermit. Then please INDUSTRY Maine Artist & clothes designer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Alfred Gibbon Mildred Witham IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. permit. (Yes, no, or unknown) (If yes give wor or dotes of service) 220-54-6005 Springfield State Hospital Records 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p burial, crematic ONSET AND DEATH PART I. DEATH WAS CAUSED BY Arteriosclerotic Heart Disease IMMEDIATE CAUSE (o) DUE TO Generalized Arteriosclerosis Years Conditions, if ony, which gove (b) rise to immediate couse (a). DUE TO stoting the underlying couse as the Page 4 may be retained by the hospital ar attending O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES 🗍 NO X CBS assoc. with cerebral arteriosclerosis without qualifying phrase far 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING detached for te Dept. af I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20e. PLACE OF INJURY (Home, form, (County) 20d. INJURY OCCURRED factory, street, office bldg., etc.) Not While ot work 21. I certify that (1) (this haspitol) attended the deceased from 1-22-64 3=3=67 __, 19___, that (1) (we) last and that death accurred at 5:30 m. from causes and an the date stated above saw the deceosed alive on_ 3-3-67 19 22b. DAJE SIGNED -220. SIGNATURE ATTENDING PHYS. STAFF PHYS. K DIRECTOR 22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784 22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D. director, should be 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION, BREMOVAL (Specify) South Side 26b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR Marley Judge VR A15 (4) 20 M 1/66 DATEMAR 7 1967

15 It n. 2. Tran from Laurel San which has be . . . absed for several year. No further information available. Ans. 4/7/67 appropriate the manufacture distribution of the contract Appearance in hours or sender The rice of the ri Pulturante i Asia violita in accompliano estran legion do ella massilia

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after deal Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03438
CERTIFICATE OF DEATH

00400	OEIT III ION I	E OI DEATH	00204
1. PLACE OF DEATH a. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution a. STATE b. COUNTY Maryland Carrol	
b. CITY OR TOWN (if outside corporate limits, write BURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RUF	RAL and give nearest town)
16 ood frue	6 Months	Rural-Mt. Airy	06-1
d. NAME OF HOSPITAL OR INSTITUTION (if not in h	ospital, give street address)	d. STREET ADDRESS R • D •	e. IS RESIDENCE ON A FARM? YES NO
3. MAME OF DECEASED (Type or print)	Middle	Last 4. DATE Month OF DEATH	Day Year 2 / 1967
5. SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH 9. AGE Of years IF UND	DER 1 YEAR IF UNDER 24 HRS.
Sexual While WIDOWED	DIVORCED	Nov. 13, 1884 last birthday) Month	is Days Hours Min.
	IND OF BUSINESS OR		. CITIZEN OF WHAT
Housewife	MDOSIKI	Carroll Co., Md.	J.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Harry E. Kidd		Sarah E. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. (Yes, no, or unknown) [(If yes give war or dates of service)]	SOCIAL SECURITY NO. 17.	INFORMANT Address	
No Progression and dates of service,	6-09-84761	ir. William Kidd Sykesvil	Lle, Md.
18. CAUSE OF DEATH [Enter only one cause per l		2 1 M	I INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerelia	I Mas Culy Wellike	ONSET AND DEATH
4222 DUE TO	al		Q
Conditions, If any, which) (b)	Chr 60	ue Carlio Volular	./
gave rise to Immediate (cause (a), stating the DUE TO			-
underlying cause last. (c)			
ICAT	UTING TO DEATH BUT NOT REL	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1	(a) 19. WAS AUTOPSY PERFORMED? YES NO
	DESCRIBE HOW INJURY OCC	URRED. (Enter nature of injury in Part I or Part II of Item	18.)
	NJURY OCCURRED 20e. PL	ACE OF INJURY (Home, farm, 20f. (City or town) (ory, street, office bidg., etc.)	(County) (State)
Hour a.m. While at wor	- NOT MULLS	ory, an eat, once bing, etc.,	1000
21. I certify that (I) (this hospital) attend			that (I) (we) last
saw the deceased alive on section of	196 /, and tha	at death occurred at M, from the causes and o	n the date stated above. PATE SIGNED
THE HE Mask	m.	D. ATTENDING MED. STAFF DIRECTOR PHYS.	23/-67
220. PHYSICIAN'S NAME (Type)	9TIN	22d. ADDRESS.	Jud
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)	23c. NAME OF CEMETER		
Burial 14/3/1967	Pine Grove	Mt. Airy, Md.	
C. M. Waltz Box 241 Sy	ADDRESS kesville, Mo		AR'S SIGNATURE
100000000000000000000000000000000000000		DATE	U

VR AI5 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) in by the funeral o. COUNTY o. STATE MARYLAND c. LENGTH OF STAY IN 1b outside corporate limits, write RURAL and give nearest town outside corporate limits write RURAL and give nearest town) INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON, A FARM? filled 60 NO NAME OF Middle 4. DATE Month carban · T Lost Dov Year and campletely DECEASED (Type or print) DEATH S. SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE NEVER MARRIED remave last birthdoy) Months Hours Dovs dny WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) LNDUSTRY COUNTRY? ARYLAND SHOVEL OPERAT 13. FATHER'S NAME the attending phy: 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) b UNION BRIDGE 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) . COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF, STAY IN 16 c. CITY OR TOWN (F outside corporete limits, write RURAL and give nearest lown) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) . IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO completely NAME OF Midale 4. DATE Day Yaar Month DECEASED OF (Type or print) DEATH 19 avenue and cor 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years | IF UNDER 1 YEAR 5. SEX IF UNDER 24 HRS. DATE OF BIRTH last birthday) Months Days Hours MIn. 10s. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE foreign country) done during most of working life, even if retired) 13. FATHER'S NAME MOTHER'S MAIDEN NAM 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gava rise to immediata cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? 2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) (Stata) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) factory, street, office bldg., etc.) While Not While Hour a.m. at work et work p.m. CIO hould 21. I certify that (I) (this hospital) attended the deceased from. saw the deceased alive on March 22b. DATE 22a. SIGNATURE SIGNED ATTENDING DIRECTOR PHYS. death. Page 4 22d. ADDRESS PHYSICIAN'S NAME ITYDO director, be filed 3a. BURIAL, CREMATION, 25b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 1967 Mt. Carmel Cemetery Parkton. Md. Burnal 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** VR A15 (4) Tipton - Eline Funeral Home Hampstead, Md. 15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) O. COUNTY RROLL o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. write RURAL and give nearest town) FINKCBURG VESTMINSTER d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES T NO C requires that the death certificate be executed within 3. NAME OF Middle 4. DATE Year DECEASED HANSEN 19 (Type or print) DEATH S SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years birthdov) Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) SELF COUNTRY? **INDUSTRY** CARROLL CO MD FARMER AND CA EMPLOYE CHARLES AUGUST HANSEN IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) MR. FRANCIS R. HANSE 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-transit p PART I. DEATH WAS CAUSED BY: BRONCHO PIVEUMENIA IMMEDIATE CAUSE (o) DUE TO buriol, Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) REBKIAL VASCLLIAR YES [NO L 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While , 1967, to 19 62, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 1967, and that death occurred at 622 M, from causes and on the date stated obove. sow the deceased alive on 220 STGRATURE 22b. DATE SIGNED **ATTENDING** M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, 230. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Charles VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH

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O HOSPITAL Page 4 may O FUNERAL director, pa		NAME (Type) C. L. 131/1/195/ca WestmingliziVII	aryland
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03445
CERTIFICATE OF DEATH

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	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 last birthday) Months I. I.	
5	/	MALE WHITE WIDOWED DIVORCED	act 2 - 1883 Rast birthday) Months I	Days Hours Min.
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		7	Curroll Co Md W.	INTRY?
	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
		Elizaht. Holfacker	Joanna Harl	
	15. (Ye	no an universal (15 year nive was as dated of calculate)	INFORMANT Address	
9		No 215-503294	his Harry annacont appear	co, ud
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
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	SAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, farm, 20f. (City or town) (Cour	ty) (State)
	MEDICAL	Hour a.m. While Not While at work	ry, street, office bldg., etc.)	
ď	Σ	21. I certify that (I) (this hospital) attended the deceased from	7/7 1966 to 3/14 196	Z that (1) (we) last
			t death occurred at 3 cs. M, from the causes and on th	
		22a. SIGNATURE, 1	22b. DA	TE SIGNED
		Wood M.D	D. ATTENDING MED. STAFF PHYS. 3/	14/67
		22c. PHYSICIAN'S NAME (Type) A 1 + Fa 4 - 1	22d. ADDRESS	12112
1		VV.11 10 (11 d /01.1)	MANCHESTERMS	1 21102
	23a	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY 3/17/67 St. Peter 1st.		ity) (State)
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	13.	FATHER'S NAME	< x	m			14.	MOTHER'S MAIL	DEN NAME		45	7
	15. (Ye	WAS DECEASED EV	ER IN U.S. ARM	ED FORCES?	16. SOCIA	L SECURITY NO	17. INFO	DRMANT	chan 6	Address	1 Frul	and pul.
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np		BURIAL, CREMAT	13/	THEREOF	7 1236.	name of cen	TOWN	CREMATORY / CMETE	cy FI	CATION (City, 16) 100/JN STRAR 256. REC	d, /	(State)
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MARYLAND STATE DEPARTMENT OF HEALTH

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FOR STATE	03448 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	1442
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Page State D hours a	Springfield State Hespital, Sykesville 4516 Umatilla Avenue	YES NOW
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uted within in pencil Examiner's Examiner's in sit permit or remove	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]	ONSET AND DEATH
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Be be ed	p.m. 19 at work at work 21. certify that took charge of the remains described above, held an Autopsy , Inspection , Inquiry ,	and in my opinion
EXAM e cert hould iles. OR: Pa signat	death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner	
de se la	CHIEF MEDICAL EXAMINER	
MEDICA Page 4 or your	SIGNATURE MODELLE M.O. ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
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O DEPUTY M please exec director. Paretained for C FUNERAL of Health or	NAME (Type) W. Glenn Speicher, M.D. Address (Street Mycrosch of country 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or country)	inty) (state)
of direction of L	REMOVAL (Specify) 3/21/1967 Belto Helrew Belto, md	104
	24. FUNERAL DIRECTOR	SSIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH

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ARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03451 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission), PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll MARYLAND Baltimore City Maryland Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) the attending physician and campletely filled in by the sit permit. Then please remove carban papers. Pages nation, or removal, and in any event, within 72 hours aft b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Baltimore Lyrs. 3mos. 2/1dvs Sykesville e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) 1109 S. Kenwood Ave. YES NO TO Springfield State Hospital 3. NAME OF 4. DATE Manth First Middle Last Day Year DECEASED OF KENDRZEJEWSKI ADAM ANTHONY MARCH DEATH 67 (Type or print) 5. SEX DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE NEVER MARRIED 7. MARRIED last birthday) Manths Dovs Haurs 12-18-07 WIDOWED DIVORCED Male White 10a. USUAL OCCUPATION (Give kind of work dane 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & Stote, or fareign country) during most of working life, even if retired)
Welder Fisher Body Div. INDUSTRY Chevrolet Co. COUNTRY? Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Frank Kendrzejewski Agnes Zaworski 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war ar dates of service 216-01-2223 Records, Springfield State Hospital crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction the hospital ar attending physician. DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if ony, which gove Years rise ta immediate cause (a), DUE TO stating the underlying couse as the priar tal for FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the 70(e) Pulmonary tuberculosis, moderately advanced, inadtive Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CBS assoc. with alcohol intoxication, without qualifying phrase 19. WAS AUTOPSY PERFORMED? for use Health NO X 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH 0 (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (State) 20c. TIME OF INJURY Month, Day, Year Haur o.m. factory, street, affice bldg., etc.) Nat While While at work at wark 21. I certify that (I) (this haspital) attended the deceased fram 12-6-62 3-30-67 __, 19____, that (I) (we) last saw the deceased alive an 3-30-67 19 , and that death accurred at M, from causes and on the date stated above. 22b. DATE SIGNED 220 SIGNATURE ATTENDING 3-30-67 director, page 3 should be filed v M.D. DIRECTOR PHYS. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M. D. Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (State) 23g. BURIAL CREMATION. 23b. DATE THEREOF (County) REMOVAL (Specify) 4/3/ 67 St. Stanislaus Cemetery Baltimore Md. 256 REGISTRAR'S SIGNATURE **ADDRESS** MA REC'S BY REGISTRAS 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 John J. Duda Inc. 2829 Hudson St. Balto. Md. DATE

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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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urs af n by t Page ours a	write RURAL and give nearest town) 2 yrs 10 mo Dolleman 30.4
4 ho led i pers. 72 h	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
	Jorg View Musey Jame 1664 Shody Inde de YES NO
executed within 24 hours after and completely filled in by the papers. Page in any event, within 72 hours	NAME OF DECEASED (Type or print) Name OF DECEASED (Type or print) Name OF DATE Month Day Year DF DEATH 3 27 1967
uted com	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min.
and rem	Knule White WIDOWED DIVDRCED Sept 13,1935 31 yrs.
icate be e physician n please r val, and iff	10a. USUALOCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR line in the country line in t
ficate phy prophy prod,	13. FATHER'S NAME
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hat the death certificate be executed within cian. ed by the attending physician and completely transit permit. Then please, remove carbon is, cremation, or removal, and in any event, with	(Yes, no, or unkown) (If yes give war or dates of service) 452-56-9963 Fel. Language (1)
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oing Pi d by th After t d be de	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour a.m. While not While at work at
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	saw the declared alive on 1967, and that death occurred at 432M, from the causes and on the date stated above 22a. s GNATURE 22b. DATE SIGNED
	M.D. ATTENDING MED. STAFF 3/27/67
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FO HOSPITAL Page 4 may fo FUNERAL director, pa should be fi	23a. BUBLAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
F 7	24. FUNERAL DIRECTOR ADDRESS 125a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15 (4)	John & Hoff. Hamesteed mx DAVERD 21 1967 goliarles Judge
15M 4-64	MAK 9 1 KM



AND DECODDS 201 W DESTAN STREET RAITIMORE MARYLAND 21201

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be re be re ge 3 ge 3 led w		220. SIGNATURE Jahres 5- Ha	when M.	D. ATTENDING MED. STAFF DIRECTOR PHYS.	22b. DATE SIGNED
SPI 4 n d b	23/	NAME (Type) OHN S. H.	4 RS CHEY M.D.	Y suchorst Wester	(County) (Stote)
	B	REMOVAL (Specify) 3/4/67 FUNERAL DIRECTOR	Trenton Cen	netery Upperco Bal	to. Co. Md.
VR A15 (4) . 20 M 1/66		Tiptom - Eline Funeral Ho	ome Hampstead,		carles Judge

C ACCUMENT and the firmed to Many · Continue to state in the state of nest and state of the contract
CERTIFICATE funeral PLACE OF DEATH a. COUNTY MARYLAND 242 by th b. CITY OR TOWN liff outside corporete limits, c. LENGTH OF STAY IN 16 write RURAL and give neerest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) mpletely papers NAME OF Middle Last DECEASED (Type or print) 5. SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED and WIDOWED DIVORCED ton, USUAL OCCUPATION (Give kind of work гетоме 10b. KIND OF BUSINESS OR INDUSTRY done during most of working life even if retired) 13. FATHER'S NAME please 16. SOCIAL SECURITY NO. 1 INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no cor unkown) | (If yes give wer or detes of service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), signed by PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUF TO Conditions, if eny, which gave rise lo immadiata ceuse DUE TO (a), stating the underlying cause last. the 20a. ACCIDENT WAS UNDERLYING - 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Part II of item 18.) for OR CONTRIBUTING CAUSE OF DEATH 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Dev. Yeer While Not While Hour a.m. et work al work the deceased alive on Much .19.6 22a. SIGNATURE PHYS. page 22c. PHYSICIAN'S NAME ITYPE 23c. NAME OF CEMETERY OR CREMATORY BURIAL CREMATION, 236 DATE THEREOF REMOVAL (Specify) 24 PUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH 2. USUAL BESIDENCE (Where deceased lived, If institution: Residence before admission b. COUNTY OR TOWN (If outside corporete limits, write RURAL end give neerest town) d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO DATE Dev Yaar 4. Month OF DEATH 19 ane 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthdayl Months Hours Min. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY 14. MOTHER'S MAIDEN NAME INTERVAL BETWEEN ONSET AND DEATH PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6): 19. WAS AUTOPSY PERFORMED NO (Stete) 20f. (City or town) (County) factory, street, office bldg., etc.) to. 22b. DATE ATTENDING DIRECTOR PHYS. 22d. ADDRESS LOCATION (City, town or county (State) 25e. REC'D BY REGISTRAR 255. REGISTRAR'S SIGNATURE DATE

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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMOR	F 1. MARYLAND
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ING PHYSICIAN: The law requires that the death certificate be executed within the hospital or attending physician. After this certificate has been signed by the attending physician and completely be detached for use as the burial-transit permit. Then please remoye carbon state Dept. of Health prior to burial, cremation, or removal, and in any event, with	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Jenerally durterrocklerone (c)	is you
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ING PHYSICI d by the hosp After this cel 1 be detached State Dept. c	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work et work	(County) (State)
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ATTI reta ECTO 3 sho with	saw the deceased alive on ward 17 19 67, and that death occurred at 222. SIGNATURE	nd on the date stated above 22b. Date signed
AL OR nay be IL DIRE page 3 page 3	M.D. ATTENDING MED. STAFF DIRECTOR DIRE	3/19/67
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

(22)			03457	CERTIFICATE	OF DEATH	03	451
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AL DIRECT poge 3 she filed with			220. SIGNATURE	M.D	ATTENDING MED. S PHYS. DIRECTOR P 22d. ADDRESS	TAFF 22b. DATE SIGNE	167
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Page 4 m To FUNER/ director, should be	8		BURIAL CREMATION, 23b. DATE THEREOF PROVAL (Specify)	967 Belaur	Memory Bo	Cer Had 2sb_ registrar's signature	ned
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 haurs after death and completely filled in by the funeral remave cochan papers. Pages 1/and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Carroll MARYLAND Maryl and b. CITY OR TOWN (If autside carporote limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) write RURAL and give nearest town) remave cochan papers. Pag n any event, within 72 haurs Baltimore d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) 1524 Schenley Road Springfield State Hospital 3. NAME OF Middle DATE First Last DECEASED OF Raymond Herman Moreau (Type or print) DEATH S. SEX 9. AGE (In years 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH NEVER MARRIED last birthday) 7-28-97 White Male WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign country) during mast af warking life, even if retired) INDUSTRY Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Otto Moreau 1S. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, ng. ar unknawn) (If yes give war ar dates af service 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c), signed by the burial-transit p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause as the has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use Health Chronic brain syndrome associated with senile brain 20g. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, form, 20d. INJURY OCCURRED (City ar tawn) 20c. TIME OF INJURY Manth, Day, Year Haur a.m factory, street, affice bldg., etc.) Nat While ot wark at wark

e. IS RESIDENCE ON A FARM? YES NO IX Manth Day Year 19 6 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Haurs 12. CITIZEN OF WHAT COUNTRY 2 Augusta Mingerson Springfield State Hospital INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? ction. O FUNERAL DIRECTOR: After this certificate (State) (County) 21. I certify that (I) (this haspital), attended the deceased fram. 19. 7, that (I) (we) last and that death accurred at 1150 P.M., from causes and an the date stated above. saw the deceased alive an. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Springfield NAME (Type) NAN 0 director, 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify)
Burial 3/8/67 Dulaney Valley Baltimore Co., Md. 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md. 21202 Charles 1967 20 M 1/66

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	in b Pa hours	Manchester 8 years 4 mes Baltimore City	30-4
	24 fillect fillect paper in 72	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Long View Nursing Home Inc 3031, Edge wood Ave	e. IS RESIDENCE ON A FARM? YES NO
		3. NAME DF First Middle Last 4. DATE Month	Day Year
	complex ve car event,	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER)	17 196) 1 YEAR IF UNDER 24 HRS
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	of it.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) 217-03-1913) Seorge Nelson Manchestee	Marila
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	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use as the burial-transit should be filed with the State Dept. of Health prior to burial, crema	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.	<u>, </u>
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	Page O FU direct Shou	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or countries and survival 3/20/67. Moreland Memorial Cem. Baltimore, Modern Memorial Cem.	
	7	24. FUNERAL DIRECTOR 3/20/67. Moreland Memorial Cem. Baltimore, Md ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR 25b	'S SIGNATURE
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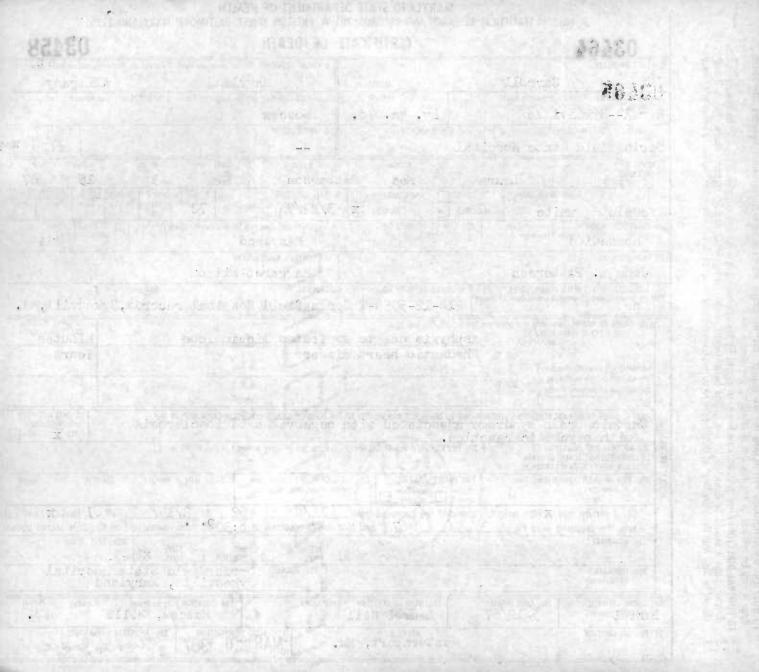
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03463 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after deoth ottending physician ond completely filled in by the funeral permit. Then please removeracibon papers. Pages I and permit within 72 hours after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY o. STATE b. COUNTY Carroll MARYLAND Maryland Carroll b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) Taneytown Tanevtown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO E E. Baltimore Street E. Baltimore Street 3. NAME OF Middle 4. DATE Day Year DECEASED event, 1967 (Type or print) Pauline Ohler DEATH IF UNDER 1 YEAR Ethe] March 9. AGE (In years IF UNDER 24 HRS. S. SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Months Dovs Haurs WIDOWED DIVORCED 1893 Female White 16. 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR Carro County State or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY? Housework
13. FATHER'S NAME Maryland II.S.A 14. MOTHER'S MAIDEN NAME Anna Loretta Koons William Daniel Ohler 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates af service) 215-32-3213 Mr. Delmont Koons, Taneytown, Maryland INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). signed by the burial-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate hos been the Heolth prior to PHYSICIAN: The low PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED CERTIFICATION for 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Not While factory, street, affice bldg., etc.) ot wark pe 21. I certify that (1) (this haspital) attended the deceased fram Microch 5, 1967, to March 17, 1961, that the (we) last saw the deceased alive an March 12, 1962, and that death accurred at 6 M. M, fram causes and an the date stated above. TO HOSPITAL OR ATTEND Poge 4 may be retained 22n SIGNATURE 22b. ATTENDING DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Ambler Thompson Taneytown. Md. NAME (Type) director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Grace Reformed Cemetery Mar. 25.1 Taneytown, Maryland 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66 C.O.Fuss & Son Taneytown, Maryland

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03465 ond 2 deoth. 24 hours ofter deoth the ottending physician and completely filled in by the funeral sit permit. Then please remove cardon popers. Pages I and motion, or removal, and in any event, within 72 hours ofter deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission a. COUNTY b. COUNTY Carroll Maryland MARYLAND b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn)

Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) h days Baltimore e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital 900 Cathedral Street YES NO X event within PHYSICIAN: The low requires that the death certificate be executed within 3. NAME OF 4. DATE Last Month Year DECEASED (Type or print) RUTH LOUISE PRICE March 21 19 67 DEATH AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS. S. SFX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Days Haurs Female White 10-15-83:02 WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT red Pustry COUNTRY? during most of working life, even if retired)

Bank employee Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Tully Price Annette B. White 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, na, ar unknawn) (If yes give war ar dates af service) 220-24-3777 Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) INTERVAL BETWEEN signed by the buriol-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH Conjestive Heart Failure IMMEDIATE CAUSE (a) DUF TO Conditions, if any, which gave Coronary Disease vears rise to immediate couse (o), DUE TO stating the underlying cause O HOSPITAL OR ATTENDING PHYSICIAN: The low re Poge 4 may be retained by the hospital or ottending os the O FUNERAL DIRECTOR: After this certificate has been Diabetes years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? for use Schizophrenic reaction, chronic undifferentiated type. YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part T or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (State) 20c. TIME OF INJURY Manth, Doy, Yeor (County) factory, street, affice bldg., etc.) Not While ot wark 21. I certify that (1) (this hospital) attended the deceased from 3-17-1967, that (I) (we) lost 1967 to 3-21should saw the deceased alive on March 21 1967, and that death accurred at 1130AM, fram causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. DIRECTOR M.D. MIL 22d. ADDRESS PHYSICIAN'S Frances Reid Nabors, M. D. NAME (Type) Springfield State Hospital. Sykesville 23o. BURIAL, CREMATION, 23b. DATE THEREOF 3/25/67. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Loudon Park Cemetery Baltimore. Md. ADDRESS 2Sa. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Mcharles Leonard J. Ruck, Inc. Balto. Md. 21214

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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ENG	wid the				eceased alive an_	3	123 1967	and that	death accurred at	7.5 M, fr	am causes	and an the da	te stated abay
ATT	DIRECTOR: ge 3 shoul led with th			220. SIGNATURE		1	/	1	ATTENDING	MED.	STAFF	22b. DATE SIG	
OR De re	N P	32		1/1	ment	7.92	cacco	M.D.	PHYS.	DIRECTOR	PHYS.	3/2	3/67
AL V	AL DIII page e filed	300		22c PHYSICIAN'S NAME (Type		,			22d. ADDRESS				
P. m	ERA or, F	1		MAME (Type	ATTICATIO 6		co, Jr.			Street,			Md.
Page 4 may b	director, pa		230	. BURIAL, CREMATION REMOVAL (Specify	/h		23c. NAME OF CE			23d. LOCATIO	ON (City or To	wn) (Caunt	y) (Stote)
50	5 ⊕ ₽	0	-	REMOVAL (Specify Burial		27,1967	Luthera	n Ceme	tery	Taney D BY REGISTRAR	town,	Maryland GISTRAR'S SIGNATU	DE
	VR A15 (4)	(K)	17	7	10 1				AAAD	A 24			AL.
	20 M 1/66	V	17	hn H.S.	KILLS C.O. F	uss &	Son, Tane	ytown.	Md. DATE	27 196	1 Ju	iarles Je	use

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03470 requires that the death certificate be executed within 24 hours ofter death the attending physician and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages I and nation, or removal, and in any event, within 72 hours offer death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND Carroll Marvland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 /3 mos. Sykesville Baltimore 21202 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 36 Market Place YES | NO X 3. NAME OF First Middle 4. DATE Doy Year DECEASED William NMN SHENK (Type or print) DEATH March 10 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthdoy) Months Hours Doys Settorced x male white 1-25-1912 WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN DF WHAT during most of working life, even if retired) INDUSTRX COUNTRY? Pennsylvania U.S.A Porter 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William J. Shenk - dec. dec Marv -15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service)
yes Nat 1 Guard 1930-Springfield State Hospital Records 171-09-2913 18. CAUSE OF DEATH (Enter only one-cause per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit Weeks Tuberculous pneumonia IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or ottending physician DIJE TO signed I Conditions, if ony, which gove Pulmonary tuberculosis vears rise to immediate couse (o), DUE TD stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been use os the lost WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) for use Heolth YES X NO CBS assoc. with alcoholic intoxication with behavioral reaction. 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 0 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work ot work 21. I certify that (1) (this haspital) attended the deceased from 11-17-65 ta 3-10-67, 19__, that (1) (we) last saw the deceased alive an 3-10-67 and that death accurred at 8:30 no from causes and an the date stated above. 19 22b. DATE SIGNED -22a. SIGNATURE STAFF PHYS. 3-11-67 DIRECTOR Springfield State Hospital 22d. ADDRESS PHYSICIAN'S Antonius Glaha, M.D. NAME (Type) Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d LOCATION (City or Town) (County) (State) 230. BURIAL, CREMATION, REMOVAL (Specify) Mar. 14.19 Juria PONERAL DIRECTOR 256 REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

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1	3	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.
FOR STATE		03471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH U3465
HEALTH DEPT.	1.	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. COUNTY
		Carroll Maryland Carroll
cessary, funeral may be artment r death.		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Description: C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
ceessa the fune 5 may Department	_	Rural Taneytown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
to the lige to the Dete Dete Dete		ON A FARM?
delay k nd 3 to Page State hours	3.	NAME OF First Middle Last I.4. DATE Month Day Year
13. and 14. an		DECEASED (Type or print) HAR VEV WILLIAM SHORB DEATH 3 14 19 67
書書	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. last birthday) Months Days Hours Min.
death. Pages ith for		Male White WIDOWED DIVORCED Nov. 6, 1925 41 yrs. William Willi
e a w	dur	. USUAL OCCUPATION (Give kind of work done industry) Ing most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) COUNTRY?
purs after 18. Grant 19. G	13.	Automobile Dealer Retail Sales Maryland U.S.A.
t hours ltem 18 ffice al ffice al		Edward Shorb Clara Ohler
n Iten n Iten Office File	15 (Ye	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address s, no, or unknown) (If yes give war or dates of service)
within pencil in miner's permit.		Yes WW II 212-24-3536 Mrs. Harvey W. Shorb, R#1, Taneytown, Md.
certificate should be executed within 24 hou ting the word "pending" in pencil in Item led to the Chief Medical Examiner's Office d be used as a burial-transit permit. File prior to burial, cremation, or removal, and li		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I, DEATH WAS CAUSED BY:
Exa Exa		IMMEDIATE CAUSE (a) Control of Manual Control of Contro
uld be executed I "pending" in off Medical Exar a burial-transit cremation, or		Conditions, If any, which) Hypertension of Conditions, If any, which)
d be "pe Me buri		gave rise to immediate cause (e), stating the DUE TO
houl ord Shief is a		underlying cause last. (c)
writing the word writing the word arded to the Chief ould be used as a burior to burial, co	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO X
tiffication to	IFIC/	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
R: This certificate, writing forwarded to 3 should be agent, prior	CERT	PRIMARY Or CONTRIBUTING Cause of Death.
H A		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
NER: The filtrate, be forw ge 3 shed agen	MEDICAL	p.m. 19 at work at work
EXAMI certi nould k les. IR: Pag signate		21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion
the certific should be files.	10	death resulted from: Natural eauses Accident, Suicide, Homicide, Undetermined manner
4 1 0		ACTUAL (NT) O(1) NO (1) ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
xecute Page for you AL BIRE	-	DEPUTY MEDICAL EXAMINER
DEPUTY lease ex rrector. stained f FUNERAL		NAME (Type) W. Glenn Speicher Advos (Sittle Louis of the Carrolf)
o DEPU please director retaine of FUNE of Heal	238	REMOVAL (Specify)
= =	24	Burial Mar. 17, 1967 Keysville Cemetery Keysville, Maryland FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE
VR A15ME	J	ohn H. Skiles C.O. Fuss & Son, Taneytown, Md. MAR I 6 1967 Gliones Judge
3500 4-64	-	V.

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1 2	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	03472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03468
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY b. COUNTY c. STATE c. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE c. OUNTY c. STATE c. COUNTY c. COUNT
ent be	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
necessary. The funeral may be may be may be partment fer death.	RUTAL SUKESVILLE Minutes RUTAL SYKESVILLE 06-1
o the after	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
lelay is necessary and 3 to the funeral Page 5 may be State Department hours after death.	Route 32 Koute / YES NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOT
M3. all	(Type or print) RUTH ATTRIE SIMPKINS DEATH MARCH 14, 1967
tth. If all form P form P within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. Months Days Hours Min.
with for	10a, USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
Give Give	during most of working life, even if retired) INDUSTRY HOSPITAL MAY band U.S. A.
ours after a long a long pages In any	13. FATHER'S NAME Edulated Devilbiss 14. MOTHER'S MAIDEN NAME TOSCODA?
24 ho Office Office File	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
within 2 pencil in miner's O permit. I	(Yes, no., or unknown) (If yes give war or dates of service) 215-16-9614 MR. Stephen Simpkins - Sykesuille, Md.
n per amin t per	18. CAUSE OF DEATH [Enter only one cause per lipe for (a), (b), and (c), I PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND BEATH
"pending" in f Medical Exar burial-transit cremation, or	MMEDIATE CAUSE (a) DUE TO
ld be execu "pending", f Medical burial-tran cremation,	Conditions, if eny, which gave rise to immediate (b)
ould "Ilef Nief Nief I, cre	cause (e), stating the DUE TO underlying cause last. (c)
ficate shouthe word to the Chief of the Chief used as a to burial,	La Ula Ula Ula Company
tiffcal g the to the r to	YES NO ZO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If ecute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form for your files. L DRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with or its designated agent, prior to burial, cremation, or removal, and in any event within the contraction of the c	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS? PERFORMED? YES NO SET IN OF PART 11 OF PART 11 OF PART 11 OF PART 11 OF PART 12 OF PART 12 OF PART 13 OF PART 13 OF PART 14 OF PART 14 OF PART 14 OF PART 15 OF PART 16 OF PART 17 OF PART 17 OF PART 18 OF PART 19 OF PA
R: Thi ate, 1 forwa 3 sho agent	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour and p.m. 3-14 1967 While at work Not While at work Reute 3 2 RSI Syklesuille Canally.
MINE Triffication of the sage	21. I certify that I took charge of the remains described above, held an Autopsy , Inspection X, Inquiry , and in my opinion
L EXAL he ce should files. FOR: P	death resulted from: Natural causes A. Accident X, Suicide , Homicide , Undetermined manner
DEPUTY MEDICAL EXAMINE lease execute the certific tector. Page 4 should be etained for your files. Funeral DRECTOR. Page f Health or its designated	ACTUAL SIGNATURE WALLES OF THE SIGNED M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED 3.141/27
~ × - = -	DEPUTY MEDICAL EXAMINER
o beputy please e director. retained of Health	EXAMINER'S NAME (Type) W. G. Lenn Speicher Mores (Street Approximation) 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LACATION (City, town or county) (County)
TO BEPUT please director retained of Heali	BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BRITINDER WA-
	24. FUNERAL DIRECTOR ADDRESS 25a. AEC'D BY REGISTRAR'S SIGNATURE
3500 4-64	Harry W. Haight Sykesville, Md. MAR I 6 1967 feliarles Judge

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral PLACE OF 2. USUAL RESIDENCE (Where deceased livad, If Institution, Residence before admission) a. COUNTY b. COUNTY the day MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 2 SOUTH YES NO 4 NAME OF 4. DATE Dey Middle Month 72 DECEASED OF (Type or print) DEATH 196 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH IF UNDER 24 HRS. 8. 9. AGE (In years | IF UNDER 1 YEAR last birthday) Months WIDOWED DIVORCED physician USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. & Stele, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, avan if refired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unknwn) | (Hyesgivewar or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] NTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) しいしのひと DUE TO descenden colon Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO X 2De. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, ferm, ! 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 1 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While Hour a.m. at work at work p.m 1941, 19 (v.), that (I) (we) last 21. 1 certify that (1) (this hospital) attended the deceased from saw the deceased alive on..... 196/ 22a. SIGNATUR ATTENDING MED STAFF DIRECTOR PHYS. PHYS. M.D. death. Page 4
O FUNERAL page with t 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, be filed 23a. BURIAL, CREMATION, | 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county (Steta) OF 25b 24 FUNERAL DIRECTOR'S SIGNATURE . REC'D BY REGISTRAR VR A15 (4) 1SM 7/61

es that the

RTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03474
CERTIFICATE OF DEATH

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1. PLACE OF DEAT a. COUNTY	H		2. USUAL RESIDEN	CE (Where deceased lived, If insti-	tution: Residence before admission)
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b. CITY OR TOY	VN (if outside corporate lim		c. CITY OR TOWN (II	outside corporate limits, write	RURAL and give nearest town)
Sykesvi	and give nearest town)	IYR, 2 mos		imore	2 /
		not in hospital, give street address)			9. IS RESIDENCE
			3716 Moh	nawk Avenue	ON A FARM?
	ield State Hos	spital	2211 W. Ro	ogers Ave.,	YES NO X
3. NAME DF DECEASED	First	Middle	Last	4. DATE Month	Oay Year
(Type or print)	HERBERT TUE	RNER SNYDER		DEATH 3	25 1967
5. SEX	6. COLOR OR RACE 7. M	ARRIED NEVER MARRIEO	8. DATE OF BIRTH	9. AGE (In years II	UNOER 1 YEAR IF UNDER 24 HRS.
Male	White W	DOWED OIVORCED	3-8-1880	ast birthday) M	lonths Oays Hours Min.
10a. USUAL OCCUPA	TION (Give kind of work done	10b. KINO OF BUSINESS OR	11. BIRTHPLACE (C	ounty & State, or foreign country)	12. CITIZEN OF WHAT
C. S. H	(ing life, even If retired) Lerring and Co	INDUSTRY	Baltimo	ore. Md.	COUNTRY? U. S.A
13. FATHER'S NAM		P •	1 14. MOTHER'S MAIC		0,2,14
*****	T 1 TIT				
	XXX John W.	Snyder ? 16. SOCIAL SECURITYNO. 17.	KX.	XXXX Annie Tu	rner
(Yes, no, or unkown)	(If yes give war or dates of services	(e) 16. SOCIAL SECURITING. JO	hn S. Snyde	er-25 Fairview	Rd.Scarsdale
unknown		216-32-7911 Re	ecords, Spri	ingfield State H	lospital, wy
		se per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND OEATH
	EATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiae mou	li eiencer.		ONSET AND CENTIL
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AT				read	PERFORMED?
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OR CONTRIBUT	WAS UNDERLYING ☐ ING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCU	IKKED, (Enter nature of	f injury in Part I or Part II of I	item 18.)
	TIFY MEDICAL EXAMINER)				
ZOC. TIME OF Hour a.s	INJURY Month, Oay, Year	footo	CE OF INJURY (Home, fa ry, street, office bldg., e	arm, 20f. (City or town)	(County) (State)
p.		While Not While at work	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	fy that (I) (this hosnital)	attended the deceased from	1-29-66	9 to 3-25	-19 67, that (I) (we) last
	ceased alive on	3 - 24 - 19 67, and that	death occurred at	30 M from the causes ar	nd on the date stated above.
22a. SIGNATU		, und that	death cocorred att		22b. DATE SIGNED
	120 1.0	Manual Ma		MEO. DIRECTOR PHYS.	3-90 17
22c. PHYSICIA		gamy M.O	22d. ADDRESS	DIRECTOR PHYS.	7000-01
NAME (T	ype) Orlanho	B. RANGE H. D	Alrino	Lold State Usk	ital Cokarille
23a. BURIAL, CREM	MATION, 23b. DATE THERE	OF 1 23c, NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City, tow	n or county) (State)
REMOVAL (Sp.	ecify)	Loudon Park		(, , , , , , , , , , , , , , , , , , ,	
Burial 24. FUNERAL DIRI	3 → 28 → 67	ADDRESS	Cemetery	Baltimore, 1	Vary land
			A.	AR 2 9 1967. R	
Lusworth	Armacost-46	00Liberty Heights	Ave. DATE		

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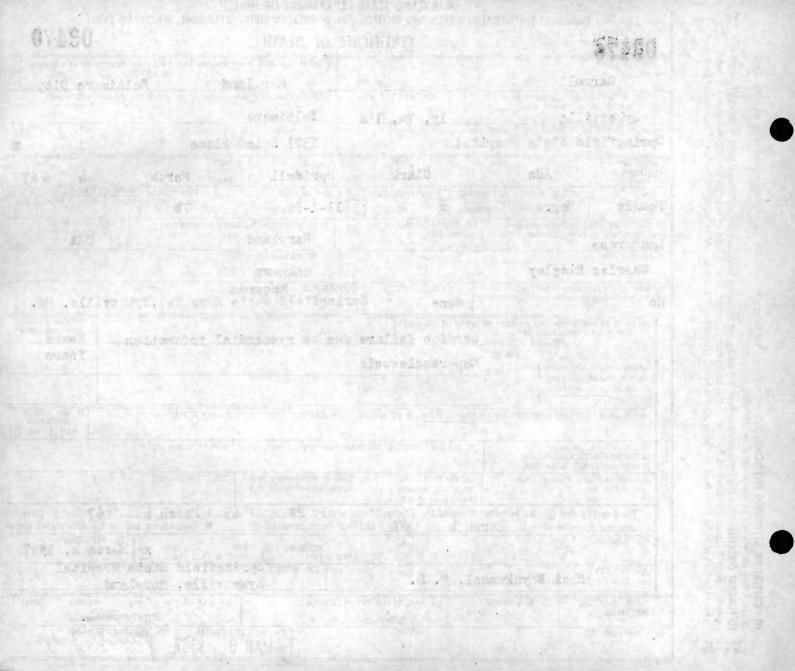
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 haurs after death physicion and campletely filled in by the funeral en please remaye carbon papers. Pages 1 and averyent, within 72 haurs after degr 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Baltimore City Carroll MARYLAND Maryland b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give neorest town) Baltimore Sykesville days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 839 Eutaw Street YES NO X requires that the death certificate be executed within 3. NAME OF First Middle 4. DATE Lost Month Day Year DECEASED JOSEPH BARKTELL SPELLMAN 2 MAR CH 67 19 (Type or print DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED **NEVER MARRIED** Jost birthdoy) Manths Days Hours 8-15-02 Male White WIDOWED Sep. DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during most af working life, even if retired) INDUSTRY Maryland Painter 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME the attending phys William Spellman (last name unk. 15. WAS DECEASED EVER IN ILS. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, ar unknown) (If yes give war or dates of service) 1926-1927 216-07-6460 Records, Springfield State Hospital Yes 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p Weeks Pyogenic abscess, left lung IMMEDIATE CAUSE (a) _ DUE TO Conditions, if ony, which gove Bronchopneumonia, bilateral days rise ta immediate cause (a), lung DUE TO attending 1 stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the Moderate pulmonary tuberculosis, upper right years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? use YES IC NO far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City ar tawn) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (State) 20c. TIME OF INJURY Month, Doy, Year foctory, street, affice bldg., etc.) Not While ot wark 21. I certify that (I) (this haspital) attended the deceased fram 2-27-67 to 3-2-67 19___, that (I) (we) last shauld and that death accurred at 7:00 M. Fram causes and an the date stated abave. saw the deceased alive an 3-2-67 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** MED. DIRECTOR 3-3-67 director, page Shauld be filed 22d. ADDRESSpringfield State Hospital 22c. PHYSICIAN'S NAME (Type) Antonius Glahn. M. D. Sykesville, Maryland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) St. Mary's Cemetery Hampden Baltimore, Md. 3-6-67 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66 VCharles 1217 St. Paul Street DATE NIAK Wm. Cook-Brooks Inc.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03470 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death the attending physician and completely filled in by the funeral sit permit. Then please remare carban papers. Pages 1 and many on the property within 72 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE b. COUNTY Carrell MARYLAND Maryland Baltimore City b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give neorest town) Sykesville Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 1321 Eutaw Place YES NO X 3. NAME OF Middle 4. OATE First Month Ooy Year OECEASEO Clark Spridell Ada March (Type or print) DEATH 19 B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIEO **NEVER MARRIEO** lost birthdoy) Months 0oys Hours Female Negro 11-1-96 WIDOWED 24 DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)

Laundress **INDUSTRY** COUNTRY? Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Charles Ridgley unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give wor or dotes of service) 17. INFORMANT Records 16. SOCIAL SECURITY NO. Springfield State Mospital, Sykesville, Md. Nene crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit ONSET AND DEATH PART I. OFATH WAS CAUSED BY Cardiac failure due to myocardial infarction CHTS IMMEDIATE CAUSE (o) signed by DUE TO Years Nephrescleresis Conditions, if ony, which gove rise to immediate couse (a). DUE TO attending | stoting the underlying couse as the this certificate hos been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO the haspital or Por 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) ot work ot work Page 4 may be retained by t 21. I certify that (1) (this haspital) attended the deceased fram July 20 , 19.65 , ta March 4 , 19.67, that (I) (we) last shauld M. fram causes and an the date stated above. saw the deceased alive an March le 1967 and that death accurred at 22b. DATE SIGNED March 4, 1967 22o. SIGNATURE ATTENOING STAFF PHYS. OIRECTOR directar, page 3 shauld be filed 22d. ADORESS Springfield State Rospital NAME (Type) Naci Buyukunsal, M. D. Sykesville, Marvland 23o. BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City of Jown) (County) (Stote) 25b. REGISTRAR'S SIGNATURE 24. FUNERAL OIRECTOR 25o. REC'O BY REGISTRAR 1967

VR A15 (4) 20 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03477 requires that the death certificate be executed within 24 haurs after death the attending physician and campletely filled in by the funeral sait permit. Then please remave carban papers. Pages 1 and sait permit. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Baltimore City MARYLAND Maryland Carrell c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Sykesville 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 336 Ilchester Ave. YES NO X NAME OF Middle Lost 4. DATE Doy Year DECEASED (Type or print) 19 67 JAMES **JEFFERSON** STARKEY MARCH DEATH IF UNDER 1 YEAR | IF UNDER 24 HRS. S. SEX DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 50 birthdoy) Months Doys Hours 2-28-17 White Mala WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done BIRTHPLACE (County & State, or foreign country)
Baltimore 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired)
Stock Clerk P.Cann Co. COUNTRY? Maryland U.S.A. Harry 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Anna Annabelle Noll James Samuel Starkev WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no. or unknown) (If yes give wor or dates of service Records, Springfield State Hospital Unk. No cremation. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN signed by the burial-transit p WOCKS ONSET, AND DEATH PART I. DEATH WAS CAUSED BY Right heart failure IMMEDIATE CAUSE (o) DUE TO Severe bilateral emphysema Years Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse Page 4 may be retained by the haspital or attending has been the last 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES X NO T TO FUNERAL DIRECTOR: After this certificate for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Dov. Yeor Hour o.m foctory, street, office bldg., etc.) Not While ot work ot work 19____, and that death accurred at 00 , 19___, that (I) (we) last 21. I certify that (1) (this hospital) attended the deceased from. shauld Martin causes and an the date stated above. saw the deceased alive on_ 3-5-67 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS. **ATTENDING** 3-6-67 X DIRECTOR M.D. 22d. ADDRESS Springfield State Hospital 22c PHYSICIAN'S Sykesville, Maryland NAME (Type) Octavio A. Ruiz. M. D. director, shauld 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (Stote) 23o. BURIAL CREMATION. REMOVAL (Specify) Baltimore, Md. Baltimore Cemetery 3/9/67 24 FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane 25p. RECID BY REGISTRAR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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23o. BURIAL, CREMATION,

REMOVAL (Specify)

24 haurs after death

requires that the death certificate be executed within

ADDRESS 24. FUNERAL DIRECTOR

DATE THEREOF 3/28/67

2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE

Johns Hopkins School/ 709 N.Wolfe St.Balto.Md.

23c. NAME OF CEMETERY OR CREMATORY Of Med 23d. LOCATION (City or Town)

Sykesville, Maryland

Milarles Judge

(County)

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eftificate be executed within 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AI5 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 021.70

-	03474		14.
1.	PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: Re	esidence before admission)
		a. STATE b. COUNTY	
-	Carroll MARYLANO b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b	Mary Land Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL)	and give nearest town)
1	write RURAL and give nearest town)	C. Offi Ok Town (if outside corporate limits, write kokke	and give nearest termy
_	Manchester 5 months	Hampstead 16	-/
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET AODRESS	e. IS RESIDENCE ON A FARM?
	Long View Nursing Home, Inc.	216 N. Main St.	YES NO T
3.	NAME OF First Middle	Last 14. DATE Month	Day Year
	DECEASED	DF	
5.	Robert Walter S	Ullivan DEATH March 8. OATE OF BIRTH 9. AGE (In years IF UNDER)	2 19 67
1	6. COLOR OR RACE 7. MARRIED NEVER MARRIED	last birthday) Months I	
	lale White WIOOWED DIVORCEO	10/22/1885 81 yrs.	
10:	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INOUSTRY INOUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12. Cl	TIZEN OF WHAT
			-S-
13	industrial Bendix FATHER'S NAME	14. MOTHER'S MAIDEN NAME	•17•
	However Carllines	Months Honor	
15	Harry Sullivan . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	Martha Hoover	
(Y	s, no, or unkown) (If yes give war or dates of service)	THE ORIGINAL Address	
	No 212-03-5270 M	rs. Paul Anderson, Hampstead,	Maryland
	18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]		INTERVAL BETWEEN
10	PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	regrenation)	ONSET AND DEATH
	1/2 21		
	Conditions If any which \	(1. l. 1/2 . p f).	7
	gave rise to immediate	Carrio Voscules Cuseful	
	cause (a), stating the DUE TO		
2	underlying cause last.) (c)		
12	PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMEO?
CA	Bours notales	Nyl Jahr	YES NO
CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU	JRBED. (Enter nature of Injury In Part I or Part II of Item 18.))
CER	OR CONTRIBUTING CLAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
		CE OF INJURY (Home, farm, 20f. (City or town) (Cour	nty) (State)
MEDICAL		ory, street, office bldg., etc.)	(0.0.0)
ME	p.m. 19 at work at work	0	
	21. I certify that (I) (this hospital) attended the deceased from	ef 6, 1966, to March 2, 196	2, that (I) (we) last
	saw the deceased alive on Filmer 28 1967, and that	t death occurred atM, from the causes and on th	e date stated above.
	22a. SIGNATURE		ATE SIGNED
	Freehold Stark. M.C	ATTENOING MEO. STAFF OIRECTOR PHYS.	3/1/17
	22c. PHYSICIAN'S	22d. ADDRESS	140
	NAME (Type)	Idamast FAD ITAK	land.
7	BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	Y OR CREMATORY 23d. LOCATION (City, town or coul	ntv) (State)
132	MEMOVAL (Specify)		
-		metery Hampsteal Md.	Carroll Co.
24	FUNERAL DIRECTOR ADDRESS		SIGNATURE
1	Pipton - Eline Funeral Home Hampstead, M	Ad. DAMAR 6 1967 garage	00
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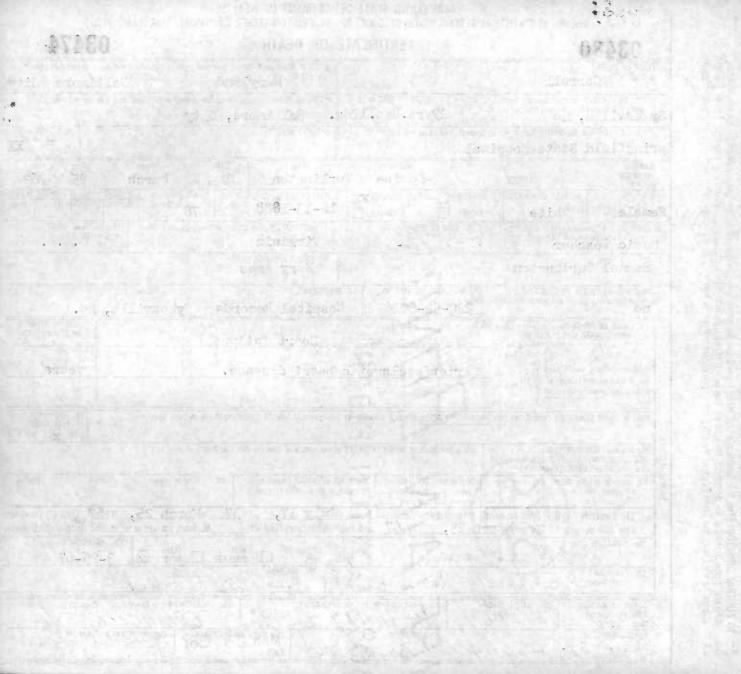
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/1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M	AARYI AND
- E2:		13481 CERTIFICATE OF DEATH	03475
death death	1.	PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: F a. COUNTY 2. STATE 4. COUNTY 4	(esidence before admission)
± 1727 ±		CARROLL MARYLAND MARYLAND CH	RROLL
0.00	0	b. CITY OR TOWN (If outside corporate limits, write RURAL and glya nearest town)	and give nearest town)
- 0 17 15	T	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
filled hin 72 h		224 WINCHESTER DRIVE 224 WINCHESTER D	YES NO
The law requires that the death certificate be executed within 22 or attending physician. Sate has been signed by the attending physician and completely fill tuse as the burial-transit permit. Then please remove carbon paparally prior to burial, cremation, or removal, and in any event, within any event.	3.	NAME DF DECEASED (Type or print) CARL CLEVELAND TWISE DEATH MARCH	Day Year
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ires phy n sig buri		Conditions, if any, which gave rise to immediate (b) Corcurous of the Colon	
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PHYSIC the hos this ce detache e Dept.		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (Co	unty) (State)
JING PL d by th After t d be de	MEDICAL	Hour a.m. p.m. While Not While at work factory, street, office bidg., etc.)	
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OR ATTENIOR PER PROPERTIES OF THE PROPERTIES OF SHOULD FOR THE PROPERTIES OF THE PRO		22a. SIGNATURE 22b. [DATE SIGNED
boy be bill by be		John S. Haisley M.D. ATTENDING A MED. STAFF DIRECTOR DIRECTOR DIRECTOR 3/16	0/67
TO HOSPITAL OR Page 4 may be TO FUNERAL DIAGRACIO, page should be filed		22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY M.D. & Cucho St. Wester	te, ud.
HOS Page FUN FUN Hirect hould	238	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or co	unty) (State)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY COUNTY a. STATE hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) = d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled papers. e. IS RESIDENCE d. STREET ADDRESS ON A FARM? nt, within YES NO completely carbon NAME OF Middle DATE Month Day Last 4. Year DECEASED 3 (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS | last birthday) | Months | Days | Hours | Min. 8. emove ev 7. MARRIED NEVER MARRIED and any WIDOWED DIVORCED 10a. USUAL OCCUPATION (GIVe kind of work done) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) physician pe during most of working life, even If retired) INDUSTRY COUNTRY? and certificate removal, 13. FATHER'S NAME MOTHER'S attending parmit. Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address 17. INFORMANT been signed by the atten the burial-transit permit. or to burial, cremation, or death (Yes, no, or unkown) | (If yes give war or dates of service) CAUSE OF DEATH [Enter only one cause per tine for (a), (b), and (c)c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a DUE TO Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the TO FUNERAL DIRECTOR: After this certificate has budirector, page 3 should be detached for use as the should be filed with the State Dept. of Health prior underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY 19. PERFORMED? NO' YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTHEY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm.) (County) (State) factory, street, office bldg., etc.) Hour a.m Not While at work at work be retained by 19 21. I certify that (I) (this hospital) attended the deceased from / 1961 1967, and that death occurred at 3PM, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED PHYS. DIRECTOR M.D. PHYS. Page 4 may ADDRESS PHYSICIAN'S NAME (Type) 22d. LOCATION (City, (State) BURIAL, CREMATION, NAME OF CEMETERY OR CREMATORY town or county) REMOVAL (Specify) LINERAL DIRECTOR VR A15 (4) 15M 4-64

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CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. COUNTX a. STATE b. COUNTY MARYLAND by th b. CITY OR IOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If cyriside corporete limits, write RURAL and give neerest town) write RURAL and give mearest town ander A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) hours af EET ADDRESS e. 15 RESIDENCE ON A FARM? YES NO papers. n 72 hou completely NAME OF Middle 4. DATE Month Dev Year DECEASED OF (Type or print) DEATH 19 within carbon 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) pue Months DIVORCED death certificate physician 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) Toust 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ā 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN Addres (If yes give war or dates of service) ending physician. been signed by the 18. CAUSE OF DEATH [Enter only one cause per line lor (a), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying ceuse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY CATION PERFORMED? NO 5 CERTIFIC 20a. ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING TI CAUSE OF DEATH tached for (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,) (County) (State) factory, street, office bldg., etc. While Not While MEDI Hour a.m at work et work 19 TOR 3 - 2 8 , 19.4 /, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from Media plnods from the causes and on the date stated above saw the deceased alive on 22b. DATE 22a. SIGNATURE ATTENDING SIGNED PHYS. DIRECTOR PHYS. -28-4 M.D. FUNERAL 22c PHYSICIAN 22d. ADDRESS director, be filed 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) REMOVAL (Specify) 0 .1967 Grace Reformed Cemetery Burial Tanevtown. Maryland Mar. 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 C.O. Fuss & Son, Taneytown, Md. 15M 7-62

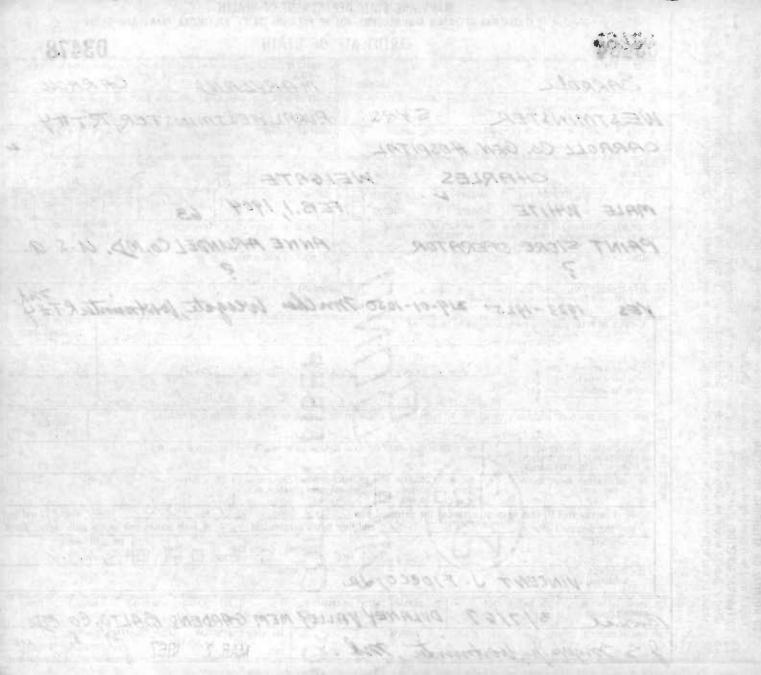
MARYLAND STATE DEPA

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

RTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after death and 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY ARROLL MARYLAND Pages c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) write RURAL and give nearest tawn) SYRS. ESTMINISTER d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street oddress) IS RESIDENCE ON A FARM? d. STREET ADDRESS CARROLL YES NO carbon 3. NAME OF Middle Lost 4. DATE Year DECEASED OF CHARLES WEIGATE 196% (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S SFX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years last birthday) Manths Hours DIVORCED and 10b. KIND OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY? ANNE ARUNDE! 13. FATHER'S NAME STORE 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, na, or unknown) (If yes give war ar dates of service) CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: burial-transit REBRAL IMMEDIATE CAUSE (o) DUF TO signed Canditians, if any, which gave ARTERIC SCEFECSIS rise to immediate cause (a), DUF TO stoting the underlying couse the hos been HRTERIOSCLERESIS GENERALITE WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO OCAR DIAL INFIARCTION 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part 1 or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or town) (Caunty) (Stote) 20c. TIME OF INJURY Month, Day, Year Haur o.m. factory, street, affice bldg., etc.) Not While at wark O FUNERAL DIRECTOR: After , 1967, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased from. 1967 to 1967, and that death accurred at 915 M, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED ATTENDING weens DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S J. Flocco; NAME (Type) director, should 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23a. BURIAL CREMATION (County) (State) REMOVAL (Specify) ALLEY 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Charley DATE



FOR STATE HEALTH DEPT. or delay is recessary, and 3 to the funeral is. Page 5 may be the State Department 72 hours after death.

2, and PM3.

D DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form

TO DEPUTY MEDI

File pages 1 and 2 with and in any event within

3 should be used as a burial-transit permit. I agent, prior to burial, cremation, or removal,

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1		09409	IV	IEDICAL	EXAMINER'S	CERTIFICAT	E UF DE	AIH	USAL	P	
	1.	PLACE OF DEATH				2. USUAL RESIDEN a. STATE	CE (Where decease	b. COUNTY	400		mission)
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2			field State		The same of the sa		Mulberry	Street		ON A F	ARM?
	3.	NAME OF DECEASED		Irst	Middle	Last	4. DATE	Month	Day	Yea	r
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	5.	SEX	6. COLOR OR RACE	7. MARRIED	1 ITETER MARKET	8. DATE OF BIRTH		E (In years IFUN st birthday) Mont		IF UNDER Hours	
1		Female	White	WIDOWED	DIVORCED	1-15-1892	74	yrs.			Min.
	10a. duri	USUAL OCCUPAT	ION (Give kind of wor ng life, even if retir	kdone 10b. K	IND OF BUSINESS OR NDUSTRY	11. BIRTHPLACE (State or foreign	country) 12	2. CITIZEN COUNTRY	OF WHAT	
-	13.	Stenogra	pher	Cal	vert School	Maryland	DEN NAME		U.	S.A.	
		Alfred V									
	15.		VITE GILE I'	ORCES? 16.	SOCIAL SECURITY NO. 17.	Mary Tu	cker	Address			
	(Yes	s, no, or unkown)	(If yes give war or dates	of service)		ecords, Spr	ingfield	State Ho	enital		
1	1		None DEATH Enter only o		Ine for (a), (b), and (c).]	corab, opi	Inglieta	50a 0e 110	LINTE	RVAL BET	WEEN
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	CERTIFICATION	20a. EXTERNAL PRIMARY XI OF CAUSE OF DEAT	CAUSE WAS CONTRIBUTING THE	20b.	DESCRIBE HOW INJURY OCCI	JRRED. (Enter neture o	of injury in Part i	or Part II of Item	1 18.)		
			NJURY Month, Day	, Year 20d. I	NJURY OCCURRED 20e. PLA	CE OF INJURY (Home, fory, street, office bldg.,	ferm, 20f. (City	y or town)	(County)	(S	tate)
	MEDICAL	Hour a.r		While at worl	Not While	ny, su cet, omce blug.,	610.)				
d	2				nains described above, he	ld an Autopsy 💢,	inspection	, inquiry	, and	in my	opinion
9		death result		al causes x/	O	icide , Homic	ide 🔲, Un	determined mani	ner 🗌		
		1	200.11		1 0	CHIEF MEDICA	AL EXAMINER			- 298	
i	ACTUAL SIGNATURE SIGNATURE ACTUAL SIGNATURE ACTUAL EXAMINER TO 22. DATE SIGNATURE TO 22. DATE SIGNATURE									IGNED	
7		EXAMINER'S, INAME (Type)	Glenn Spe	eicher,	M. D.	Address (Street	CAL EXAMINER	Comment Meile	ster	arm	fl
	23a	BURIAL, CREW		THEREOF	23c. NAME OF CEMETER	Y OR CREMATORY	23d. LOCA	FION (City, town o	r county)	148	hte)
	24	Burial FUNERAL DIRE	March	25/67	Western Cem	etery 25e. RI	Balt:	imore Ma AR 25b. REGIST	rylan	ATURE	
	270					Md. DAWAF	9 9 100	7 Milean	elen Ju	dec.	
10		Richard	V. Singl	eton	Glen Burnie,	Ma. DAVEAT	140 00		-0	0	

VR A15ME 3500 4-64

TO FUNERAL DIRECTOR: Page of Health or its designated director. Page 4 shoul retained for your files.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MAR CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, Il institutions Residence before edmission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 OR TOWN (If outside corporete limits, write RURAL and give nearest town) write RURAL and dive nearest town hours af d. NAME OF HOSPITAL OR INSTITUTION (il not in hospital, give street address) e. IS RESIDENCE 128NM ON A FARM? YES NO completely papers. 3. NAME OF Middle 4. DATE Month Year DECEASED OF (Type or print) DEATH 19 and cor IP UNDER 24 HRS. 5. SEX 9. AGE (In years | IF UNDER 1 YEAR 8. DATL OF BIRTH 7. MARRIED NEVER MARRIED Months Hours Days WIDOWED T DIVORCED AOa. USUAL OCCUPATION Give kind of work 106. KIND OF BUSINESS OR ANDUSTRY 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, evan if retired) Sconsw 13. AATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) | (If yes give war or detes of service) 18. CAUSE OF DEATH [Entar only one cause per line for (a). INTERVAL BETWEEN (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which geve rise to immediate causa DUE TO (a), stating the undarlying cause last. PARTINOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO ougrens 206. DESCRIBE HOW INJUST OCCURED. (Enter neture of injury in Part or Part II of item 18.) 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [] CAUSE OF PEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e, PLACE OF INJURY-Homa, larm, (County) (Stata) 20c. TIME OF INJURY Month, Day, Year Not Whila lactory, street, office bldg., etc.) Whila at work 19.67 10 1 1 arch 29 21. I certify that (I) (this hospital) attended the deceased from March 2.7...... saw the deceased alive on.. 22b. DATE 228. SIGNATURE SIGNED ATTENDING death. Page 4 in TO FUNERAL I DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c PHYSICIAN NAME ITYP director, p 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, town or county (State) REMOVAL (Specify) FINKS BUR BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS VR A15 (4) 15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

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